Click here to view:
Chief Executive Officer memo dated September 14, 2009 titled Final Report - Review of Proposal to Transfer Alcohol and Drug Program Administration to the Department of Mental Health

Click here to view:
Chief Executive Officer memo dated September 16, 2009 titled Final Report on Progress and Impact of the Separation of Public Health and Review of Programs with potential for transfer from the Department of Public Health to other Departments (Agenda of September 22, 2009 Supplemental Resolution Budget)

Click here to view:
Chief Executive Officer memo dated December 4, 2009 titled Final Report on Supplemental Information Related to the Final Report on Progress and Impact of the Public Health Separation and Review of Programs with Potential for Transfer (Agenda of December 15, 2009)

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 14, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

FINAL REPORT – REVIEW OF PROPOSAL TO TRANSFER ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Michael D. Antonovich instructing the Chief Executive Office to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

This represents our final report to your Board relative to the placement of ADPA. Based on our review and analysis of policy and program benefits, fiscal and administrative benefits, service delivery benefits and the implications of all those factors, as discussed in detail below, we recommend that ADPA remain in DPH.

Further, recognizing valid concerns regarding the need for enhanced integration of substance abuse and mental health services, when needed, we have instructed DPH and DMH to expedite the execution of a Memorandum of Understanding (MOU) between their Departments to further the collaboration of integrated services.

BACKGROUND

Currently, ADPA is part of DPH, remaining as part of the Public Health organization following the separation of DPH and the Department of Health Services (DHS) in 2006. It administers, through contracted providers, substance abuse services for several public social and safety programs such as California Work Opportunity and

Responsibility to Kids, General Relief, Promote Safe and Stable Families, Women Re-entry and Dependency Court, and as such, works closely with other County Departments such as DHS, DMH, and the Departments of Public Social Services, and Children and Family Services, the Sheriff's Department and the Probation Department. In FY 2008-09, ADPA's gross appropriation was $240 million, the net County cost was $6.2 million, and the total number of budgeted position was 223.0.

On July 1, 2009, we submitted to your Board an interim report on our progress and reported that a workgroup of CEO and departmental staff had been convened. Attached to the interim report were various related materials that we compiled from within and outside of the County. The packet included:

- Issue Papers prepared by DPH and DMH that provided each Department's perspective and potential impact (fiscal, programmatic and operational) on the proposed placement of ADPA in DMH;
- A listing provided by ADPA of existing programs or costs that are jointly funded by both departments;
- Excerpt from the 2004-05 Grand Jury Report to capture the Grand Jury's recommendation to merge the two Departments;
- Results of a survey we conducted on the organizational placement of alcohol and drug programs in surrounding counties and the State;
- The California Performance Review regarding consolidation of the State's Mental Health and Alcohol and Drug Programs; and
- Materials received to date from stakeholders.

Attachment I is a revised copy of our July 1, 2009 report, which now includes pages from the DMH Issue Paper which were inadvertently omitted from the attachments to our report when initially issued.

Subsequent to the release of our July interim report, we attended meetings of the Mental Health Commission, Commission on Alcoholism, and the Narcotic and Dangerous Drugs Commission to discuss the interim status report and attached background materials to allow each Commission and other attendees an opportunity to provide input on the proposal. Valuable insight was collected at the Commission meetings as further detailed later in this memo and a written response regarding the placement of ADPA was received from the Mental Health Commission by our office on August 28, 2009 (Attachment II).

ANALYSIS

The following analysis and assessment of the proposed transfer considers issues regarding policies and programs, finance and administration and the service delivery systems.

The October 7, 2008 motion referenced that a consensus of experts, supported by research literature, indicate integrated treatment approaches are most effective in treating persons with co-occurring mental health and substance abuse disorders.

Both substance abuse and mental health services share a common goal of improving human potential and function. However, as noted from the Departments, Commissions and Stakeholders, there are distinct differences in content, scope and approach to service delivery to accomplish this goal. These differences affect program design, personnel skills, and the overall scope and variety of treatment and recovery services that are available.

From a programmatic perspective, service integration is considered an effective way of supporting integrated clinical treatment. Integration of clinical treatment can enhance the development and coordination of different treatment components, and facilitate communication among clinical and administrative staff, and also be more convenient for clients, with more uniform clinical and administrative procedures. However, transferring ADPA to DMH organizationally will not itself ensure integration of these clinical services. An existing complexity for organizationally transferring ADPA to DMH is that the required program structures for each of these service delivery systems is currently disparate. Separate regulatory agencies oversee many aspects of the service delivery, and accreditation, licensing, compliance, and accountability requirements differ. Furthermore, such an organizational merger would likely require a significant investment of resources, restructuring, training, and administrative redesign that would be very difficult given the current fiscal environment.

The transfer of ADPA to DMH would impact the fiscal and administrative structures of both Departments. Currently, DMH receives no net County cost to fund salary and employee benefit cost of living adjustments (COLA's) approved by your Board, and, accordingly, would require DMH to identify resources from an already depleted Realignment funding stream to absorb future COLA's for ADPA staff that would be transferred to DMH. In addition, according to information provided by DPH, ADPA currently supports $1.8 million of administrative costs that support all components of DPH. These funds help defray costs for department wide personnel services, financial and contract services, legal assistance and information technology services, and the transfer of ADPA to DMH would result in the loss of these funds for DPH.

Furthermore, because ADPA and DMH have few funding streams in common, it is not believed that combining the two entities would result in significant increased efficiencies in financial or administrative management. Significant compliance and accountability standards exist for expenditures for both substance abuse and mental health services, and accordingly it would still be necessary to implement the same coordination of compliance standards regardless of where ADPA is placed. Finally, because the size and level of resources for the substance abuse and mental health programs differs greatly, the potential necessity of subsidizing some level of services at the expense of others may have a negative affect on service delivery.

It is recognized that ADPA and DMH serve both distinct and, at times, overlapping populations. Clinically integrated treatment for these overlapping populations, in the same geographic location and by the same clinician could result on better treatment outcomes. However, it is also true that many ADPA clients have other problems that require the services provided by or through DPH, including HIV/AIDS, other sexually transmitted diseases, tuberculosis and other communicable diseases.

In addition, in considering the implications of transferring ADPA to DMH, it must be acknowledged that the majority of individuals being treated for substance abuse do not have co-occurring disorders. During our discussions with both the Commissions and Stakeholders, this point was overwhelmingly made, and it is strongly believed that transferring the ADPA function to DMH would result in a reduction in services to the substance abuse population. This may result from prioritizing limited resources to persons with co-occurring disorders rather than those who may only need substance abuse treatment. An important consideration is that while treating substance abuse cases, medical conditions are often identified. If substance abuse services are reduced, this would create additional barriers to effective diagnosis and management of general medical conditions that are highly associated with substance abuse.

A second concern expressed regarding the transfer is the potential negative impact, or "stigma" that this could have on the outreach and treatment of substance abuse. This point was reiterated to us from both the Narcotics and Dangerous Drugs Commission and Commission on Alcoholism, as well as from DMH. The stigmatization associated with obtaining services from mental health providers is large, and influences both clients and providers in the treatment system. It is strongly felt that those individuals with a substance abuse problem, and do not have a mental health problem, are less likely to seek treatment from systems in which service delivery is seen as emblematic of mental illness.

A third concern about a possible transfer is that substance abuse is a much smaller program than mental health. There was a strong concern that substance abuse needs would not fare well in a combined organization. Substance abuse and mental health services have different service delivery models. DMH uses primarily a clinical services model. ADPA on the other hand relies on a combination of peer support, self-help, social model and clinical interventions. Reports indicate that substance abuse agencies are often given lower priority when subsumed by much larger mental health agencies. A merged mental health/substance abuse agency could result in a tiered system in which the clinical model services are favored over social model programs and services.

Finally it should be noted that clinical providers of substance abuse and mental health services often have distinct professional requirements and skills that cannot be effectively blended in current practice. Most notably, this has arisen in terms of training, licensing, and treatment philosophy. As a result of years of clinical separation, the clinical approaches cannot be easily combined, and in systems where this has occurred it has been observed that two clinical cultures remain separate in all but name.

Both ADPA and DMH acknowledge the need for a collaborative and integrated approach to address the needs of individuals with co-occurring substance abuse and serious mental illness, and have already developed integrated programs for this population. This is evidence that service integration does not require the organizational merging of programs, but rather collaboration and integration can be expanded by continued leadership from both ADPA and DMH; integrated service planning and implementation; replication, where feasible of successful evidenced based programs; a true partnership among all levels and stakeholders in the system; and the establishment of a process to identify and remove all barriers to collaboration. The development of a comprehensive MOU between DPH and DMH would serve to both memorialize existing integrated programs and services, and can be used to facilitate the development of additional collaborative efforts between ADPA and DMH.

CONCLUSION

In summary, given that DPH and DMH are already successfully collaborating on integrated treatment approaches, both agree that more can be done for the population with co-occurring afflictions, there is no evident advantage to merging the two Departments either budgetarily or programmatically, and there is no support for the transfer of ADPA to DMH by either Department or its Stakeholders, our office recommends ADPA remain in DPH and the DMH/DPH MOU be executed on an expedited timeframe to further the collaboration of integrated services.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:DAS:yb

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission
Public Health Commission

091409_HMHS_MBS_ADPA Transfer

Attachment I

County of Los Angeles
CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

July 1, 2009

Revised September 11, 2009 To Include Missing DMH Issue Paper/Exhibit A

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

PROGRESS REPORT - TRANSFER OF ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

On October 7, 2008, your Board approved a motion by Supervisor Antonovich instructing the Chief Executive Office (CEO) to develop recommendations to the Board within 30 days regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH). On October 24, 2008, we advised your Board that given the significance of the matter, additional time would be required to conduct a meaningful analysis and we anticipated providing a written progress report and a final report.

This represents our progress report to your Board relative to this effort. A working group of CEO and departmental staff has been convened and held several meetings to coordinate the various elements of our review. We have compiled and initiated our assessment of background material applicable to this study, including a 2004-05 Grand Jury recommendation on this matter, and examined programs currently integrated within the two departments. In addition, we have sought and are evaluating opinions about potential issues, the pros and cons of such a transfer, and have identified additional steps necessary to proceed with and conclude the assessment.

In general, input from substance abuse advocates recommend keeping substance abuse agencies separate from mental health agencies; and mental health input reflected the benefits of integrated programs and of providing services to address co-occurring disorders. During this Office's review of the pros and cons of such a transfer, we will identify the specific issues raised by both the proponents and opponents of the transfer to develop recommendations which address the need to improve the

coordination of care provided to clients and make optimal use of both mental health and substance abuse services. Furthermore, upon completing our meetings with the various stakeholders and obtaining their input, this Office will assess the concept of transferring ADPA to DMH against the following criteria: policy and program benefits and implications; fiscal and administrative benefits/implications to DPH, DMH, and the County overall; and service delivery benefits/implications to the service populations of DPH and DMH.

To date we have received a breadth of information from both DPH and DMH, including documentation from the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE). As a non-profit professional association of alcohol and other drug abuse agencies, CAADPE's mission is to educate the public about the need for quality alcohol and other drug abuse services to meet community needs and to actively participate in public dialogue about alcohol and drug services. Additionally, at the request of CAADPE, we met with several of their members to discuss this proposal.

Based on the information that has been obtained thus far, we have prepared the attached interim report and it will be submitted to both DPH and DMH advisory Commissions. We are scheduled to meet with the Commissions, on the following dates, to seek their input, as well as DMH's and ADPA's client and provider constituencies, regarding the placement of ADPA:

- Commission on Alcoholism, Wednesday, July 8, 2009;
- Narcotics and Dangerous Drugs Commission, Wednesday, July 15, 2009; and
- Mental Health Commission, Thursday, July 23, 2009.

The resulting information will be reviewed to finalize the assessment and formulate our final report and recommendations concerning this issue, which is targeted for August 7, 2009.

If you have any questions or need additional information, please contact me, or your staff may contact Richard Martinez at (213) 974-1758 or rmartinez@ceo.lacounty.gov or David Seidenfeld at (213) 974-1457 or dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
MLM:TOF:bjs
Attachment
c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Mental Health
Director and Health Officer, Department of Public Health
Mental Health Commission
Commission on Alcoholism
Narcotics and Dangerous Drugs Commission
Public Health Commission

PLACEMENT OF

THE LOS ANGELES COUNTY

ALCOHOL AND DRUG PROGRAM ADMINISTRATION

INTERIM REPORT

Chief Executive Office
July 2009

PLACEMENT OF THE LOS ANGELES COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATION

TABLE OF CONTENTS

- (1) Input is pending.
- (2) Input has been received.

PLACEMENT OF THE LOS ANGELES COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATION

1.0 OVERVIEW

On October 7, 2008, the Board of Supervisors (Board) instructed the Chief Executive Office (CEO) to develop recommendations regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

The concept of consolidating substance abuse and mental health services into a single agency raises several concerns and numerous agencies have previously conducted studies. To provide the Board with a comprehensive report a three phased process is being pursued.

The first phase included research of the issue, compilation of information from within and outside the County, and preparation of the Placement of the Los Angeles County Alcohol and Drug Program Interim Report (Interim Report). During the second phase, the Interim Report will be transmitted to DMH and ADPA Advisory Commissions, as well as other key stakeholders, to obtain their input regarding the proposed placement of ADPA. Once stakeholder input has been obtained, the third phase will consist of a final report to the Board, targeted for August 7, 2009. The final report will include assessment and formulation of recommendations to the Board. DMH and DPH will be provided an opportunity to comment on the report before it is finalized.

To guide and coordinate the study, a work group was convened which consisted of representatives from the CEO, DMH, and DPH.

2.0 COUNTY DEPARTMENT INPUT

As key participants and members of the work group, both DMH and DPH provided Issue Papers that identified (from their perspective), concerns, advantages, disadvantages, and other relevant information regarding the placement of ADPA.

2.1 Department of Mental Health – Issue Paper / Exhibit A

Outlines the advantages and disadvantages regarding the integration of substance abuse and mental health treatment from clinical and programmatic perspectives.

From the clinical perspective, the DMH paper conveys that the most convincing reason for such integration is the overlap in treatment populations, and that the integrated treatment for both problems in the same location by the same clinicians can result in better treatment outcomes. Clinical disadvantages include the likely separation of substance abuse treatment form general medical treatments, and the

stigmatization that integrated treatment may have on outreach and treatment of substance abuse clients. Programmatic benefits include improved coordination of different treatments and improved communication among clinical and administrative staff. A key programmatic disadvantage is that significant difference in programs structures, regulatory oversight, licensing and compliance requirements.

2.2 Department of Public Health – Issue Paper / Exhibit B

Outlines the program and policy, financial, administrative, and service delivery implications related to the concept of consolidating substance abuse and mental health services into a single agency.

The DPH issue paper outlines that there is a low likelihood for significant program integration due to underlying distinctions in the fields of substance abuse and mental health, that the placement of ADPA within DMH would diminish the integration with other public health programs (i.e. Tobacco Control, sexually transmitted disease (STD), tuberculosis (TB), and human immunodeficiency virus (HIV) Programs) focused on prevention, that no significant cost savings would be achieved with the transfer of ADPA as mental health and substance abuse funding streams differ and would still require differing program conditions and requirements, and that improved program integration could be achieved via a Memorandum of Understanding (MOU) between the two departments.

3.0 ADDITIONAL INFORMATION

The work group conducted research to obtain background information that could assist with the analysis of the placement of ADPA. It should be noted that at this point in time, the information is provided as reference and to serve as a discussion starting point. The review, analysis, options, and recommendations as to the placement of ADPA will be provided once stakeholder input, a key component of this effort, is obtained. The following information was identified as pertinent to this effort:

- Identification of programs that are currently funded as a joint effort on the part of DMH and DPH;
- 2004-05 Grand Jury Report that discussed the placement of ADPA;
- Survey of surrounding California counties identifying the placement of their ADPA operation; and
- 2004 California Report that discussed the placement of ADPA.

3.1 Jointly Funded Programs / Exhibit C

A total of 14 programs were identified in which DMH and DPH are currently collaborating in providing services to County residents. Nine programs involve $1.1 million in funding that is provided to DMH and involve services such as diagnostic services and training. Five programs involve $.5 million in funding that is provided by DMH and involve assessment, residential, and counseling services.

3.2 2004-05 Grand Jury / Exhibit D

Excerpts from the 2004-05 Grand Jury Report that discussed the creation of a Los Angeles County health authority and which County departments should be transferred to the health authority. The report incorporates analysis of related issues and implications, and the definition of the health authority's mission and functional components, including a recommendation as to the placement of ADPA.

3.3 Placement of ADP – State of California and Surrounding Counties / Exhibit E

The CEO conducted a survey of the State of California and five surrounding counties to identify the organizational structure and mission as it pertains to the health, public health, and mental/behavioral health services provided by these agencies. The State of California has a separate Department of Mental Health and a Department of Alcohol and Drug Programs. Surrounding counties surveyed; include:

- Orange County – Substance abuse and adult mental health services are organized under the Behavioral Health Services Section of the county's Health Care Agency;
- San Bernardino County – Substance abuse services are organized under the county's Department of Behavioral Health;
- Riverside County – Substance abuse and adult mental health services are organized under the county's Department of Mental Health;
- San Diego County – Substance abuse services and mental health services are organized under the Behavioral Health Section of the County's Health and Human services Agency; and
- Ventura County – Substance abuse and mental health services are organized under the Behavioral Health Section of the county's Health Care Agency.

3.4 2004 California Performance Review / Exhibit F

In 2004 the California Performance Review (CPR) issued a recommendation proposing the consolidation of the State Mental Health and Alcohol and Drug Programs. The proposal was never implemented and Exhibit F provides a summary of the CPR report. Although the matter

addressed the consolidation of Mental Health and ADP at the State level, the material provides a good summary on this important issue.

It should be noted that Exhibit G - California Association of Alcohol and Drug Program Executives (CAADPE), provides an analysis of the CPR recommendation.

Many of the findings, for and against, on the two exhibits noted above are on point as ultimately they address the proposed consolidation of the same programs.

4.0 STAKEHOLDER INPUT

A major component of any study is the input provided by its stakeholders. The Mental Health Commission, Commission on Alcoholism, and Narcotics and Dangerous Drugs Commission (Commissions), and their respective constituencies have been identified as key stakeholders. Meetings have been scheduled to solicit and obtain their valuable input on the noted dates.

The Commissions are encouraged to engage their constituencies to participate in the stakeholder process and a copy of the Interim Report will be provided, in advance of the scheduled meetings, and is intended to be used a starting point to encourage dialogue. The Commissions' Minutes will be requested and written input may also be provided, a one-week deadline will be established following each Commission meeting.

4.1 Mental Health Commission – Pending

4.1.1 Meeting scheduled for Thursday, July 23, 2009, – 500 West Temple Street, Room 739, Los Angeles, CA 90012

4.1.2 Commission Minutes and other written input may be submitted to the CEO by Thursday, July 30, 2009.

4.2 Commission on Alcoholism – Pending

4.2.1 Meeting scheduled for Wednesday, July 8, 2009, 1000 South Fremont Ave, Bldg A-9 East. Alhambra, CA 91803, Conference Room G-2

4.2.2 Commission Minutes and other written input may be submitted to the CEO by Wednesday, July 15, 2009.

4.3 Narcotics and Dangerous Drugs Commission – Pending

4.3.1 Meeting scheduled for Wednesday, July 15, 2009, 500 West Temple, Room 320. Los Angeles, CA 90012.

4.3.2 Commission Minutes and other written input may be submitted to the CEO by Wednesday, July 22, 2009.

4.4 Other Stakeholders - Pending

In addition to the input provided by the noted County commissions, the input of other stakeholders is welcomed, as of this writing the following organization contacted our office to provide input on this issue.

4.4.1 California Association of Alcohol and Drug Program Executives (CAADPE) / Exhibit G

At the request of CAADPE, a non-profit association of alcohol and other drug abuse agencies, the CEO met with several of their members. The mission of CAADPE is to educate the public about the need for quality alcohol and other drug abuses services to meet community needs and to actively participate in public dialogue about alcohol and drug services.

CAADPE provided a cover letter and several attachments which are identified as Exhibit G of this Interim Report.

EXHIBIT A

Integration of Substance Abuse and Mental Health programs in Los Angeles County: *An overview of opportunities and challenges*

Introduction:

The integration of substance abuse (SA) and mental health (MH) treatment can occur on fiscal, programmatic, and clinical levels, each with different consequences.

Clinical integration:

The argument for integration of clinical services has merit.

The most convincing reason for such integration is the overlap in treatment populations. Approximately 30% of individuals with SA diagnosis have significant additional MH problems. Over 50% of individuals with MH diagnoses have additional SA problems. Further, clinically integrated treatment for both problems—in the same geographic location and by the same clinicians—show better treatment outcomes for both the SA and mental problems.

The counter argument for clinical integration of SA and MH treatment is three-fold.

The most salient counter argument is that an undesirable but likely result of further separation of SA treatment from general medical treatment systems creates additional barriers to effective diagnosis and management of general medical conditions that are highly associated with SA, including infectious diseases such as HIV and tuberculosis, life-threatening physical withdrawals such as seizures and delirium, and toxic damage to the liver and other organs.

A second counter argument to clinical integration of SA and MH treatment is the potential negative impact that such integration may have on outreach and treatment of SA. The stigmatization associated with obtaining services from MH providers is large, and influences both clients and providers in treatment system. Those individuals and their families who perceive their problems to be SA, but who do not believe that they have MH issues, are less likely to seek treatment from systems in which enrollment is seen as emblematic of mental illness.

A third counter argument to clinical integration of SA and MH treatment is that clinical providers of these services often have distinct professional requirements and skills that cannot be effectively blended in current practice. This has arisen from the historical and fundamental separation of most SA and MH professions, in terms of training, licensing, and treatment philosophy. As a result of years of clinical separation, the clinical approaches cannot yet be easily combined. In systems that have attempted such clinical integration, it is commonly observed that two clinical cultures remain separate in all but name.

Integration of Programs:

Programmatic reasons for integration of SA and MH systems are also significant.

The most important programmatic reason for integration is that it is a powerful way of supporting integrated clinical treatment. It can greatly improve the development and coordination of different treatment components, facilitating communication among clinical and administrative staff. Sharing of clinical records is a key part of such facilitation. Programmatic integration can also be much more convenient for clients, with more uniform clinical and administrative procedures.

The counter argument for programmatic integration of SA and MH services is that the required program structures for each of these systems is currently disparate. Separate regulatory agencies oversee many aspects of operations. Accreditation, licensing, compliance, and accountability requirements differ. Information systems for MH and for SA may not be compatible in terms of either requirements or function. Further, responsibilities for public health promotion and primary prevention differ markedly.

Merging programmatic functions would require a very significant investment of resources restructuring, training, and administrative redesign during a period of likely overall resource shortage. It could potentially expose either system to serious jeopardy as a result of programmatic difficulties in the other area.

Fiscal Integration:

Fiscal integration of SA and MH services provides the potential for major simplification of service documentation, tracking, billing and reimbursement. It greatly facilitates the creation of hybrid programs and services.

The drawback of fiscal integration is that comingling of public funds for SA and MH services is permissible in only limited settings. Auditors require significant accountability for expenditures related to SA or MH in integrated settings. Also, the level of resources for SA and MH programs differs greatly, and the potential necessity of subsidizing some services at the expense of others may adversely affect some community services.

Analysis:

Integration of SA and MH systems yields benefits clinical, programmatic, and fiscal benefits. It also creates challenges and risks. Managing these challenges and risks requires a significant expenditure of resources. It is likely that current state and federal policy directions will lessen the associated clinical and regulatory hurtles over the next several years.

In Los Angeles County, ADPA and LAC DMH have already developed integrated programs for individuals with co-occurring substance abuse and serious mental illness.

(See appendix I) Balancing the clinical and programmatic benefits of further integration against its costs will determine the advisability of such action.

EXHIBIT A

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

EXISTING ELEMENTS OF INTEGRATED APPROACHES TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CLINICAL PROGRAMS

Jail Mental Health Service:

Four licensed and waivered chemical dependency counselors, employed by DMH, are placed within the Jail Mental Health Program. They provide assessment of co-occurring substance abuse and work with other clinical staff to develop an integrated treatment plan for inmates with both mental health and substance abuse problems.

Clinic-based COD programs:

The DMH Harbor/UCLA Outpatient Mental Health Center contains the Co-occurring Disorders Outpatient Services Program, consisting of integrated mental health and substance abuse staff. The program provides services to approximately thirty clients at any given time. These services address both MH and SA problems.

Hollywood, Arcadia, and Long Beach Mental Health Centers (MHCs) most extensively employ licensed substance abuse counselors in the context of mental health programs to provide integrated substance abuse treatment. Other MHCs provide substance abuse counselors for limited assessment, treatment, and consultation within the context of mental health treatment.

Community Assessment and Screening Centers (CASCs):

ADPA operated Community Assessment and Screening Centers (CASCs) provide substance abuse counselors in selected acute DMH treatment programs in order to rapidly screen and refer individuals with co-occurring SA problems to ADPA treatment programs. This provides an integrated assessment and the potential for subsequent integrated treatment as indicated. The sites are Harbor/UCLA Psychiatric Emergency Service, the Olive View Urgent Care Center (UCC), Westside UCC, and LAC+USC UCC.

MHSA programs:

Full Service Partnerships, Wellness Centers, and Client-run centers provide integrated SA services using MHSA funding specifically approved for these purposes. Licensed substance abuse counselors work within these programs to provide assessment, integrated treatment, and referral for more specialized services as necessary, including residential services.

Collaborative Service Programs:

DMH contracts with ADPA providers to operate a series of contiguous programs For example, South Bay MHC and BHS Pacifica House operate contiguously sited programs to deliver MH and SA services, with frequent consultation and joint case planning between the two staffs.

DMH funded MH services within ADPA programs:

DMH contracts with specific ADPA programs for the provision of mental health services within SA services, creating a continuum of treatment. Such contracts, e.g. with Tarzana Treatment Center and River Community, provide resources for licensed mental health clinicians to deliver onsite mental health services.

Informal Clinical Collaborations:

Multiple DMH directly operated and contracted MHCs have informal agreements as "sister facilities," facilitating ad hoc joint treatment planning for individuals with COD who are receiving services in both agencies.

DMH COD TRAINING

UCLA Integrated Substance Abuse Programs (ISAP)

DMH contracts with UCLA Integrated Substance Abuse Programs (ISAP) to provide comprehensive and ongoing training and consultation to mental health clinical staff on integrated substance abuse assessment and treatment, building competencies within DMH to work effectively in integrated treatment settings.

The COD Peer Advocate Program:

This twelve-year-old program provides comprehensive classroom and internship-based training for recovering COD consumers leading to employment in ADPA and DMH sites. Twenty individuals graduate yearly.

The UCLA Extension Integrated COD Certification Program:

ADPA/DMH sponsors this ten month program which provides specialized classroom training and networking for ADPA and MH staff in the delivery of integrated treatment, graduating thirty students per year. In its twelfth year this program provides a foundation of clinicians with enhanced competencies for development of integrated programming.

JOINT PROGRAM DEVELOPMENT AND REVIEW

Substance Abusing Mentally Ill Taskforce

The Substance Abusing Mentally Ill (SAMI) Taskforce was initiated nineteen years ago to provide a framework for joint programmatic development for ADPA and DMH agencies. This group functions as an incubation and coordination entity for a variety of programs and policy initiatives. Among the programs that it has developed are:

1. **The "Sidekicks" Mobile COD Assessment Team program**: This award-winning program was the prototype for the subsequent development of intensive case-managed programs, including Assertive Community Treatment programs and full service partnerships.
2. **The COD Peer Advocate Program:** (See above)
3. **The UCLA Extension Integrated COD Certification Program:** (See above)

Joint Training Programs:

The Statewide COD Conference is jointly sponsored by ADPA and DMH. In its seventh year, it is a pre-eminent two day conference attracting approximately 650 attendees, equally split between primarily SA and primarily MH clinical and administrative workers, to hear nationally known speakers in both fields with a focus on integrated services.

DMH Clinical COD Program Development:

DMH, with consultation from ADPA and others, has developed extensive COD assessment and treatment guidelines and assessment instruments. These are required for use with all DMH clients in order to identify and address substance abuse issues and address them within the context of mental health care and/or through collaboration with ADPA agencies. These guidelines and instruments include the 9-Point treatment planning module, the supplemental substance abuse assessment tool, and the DMH parameters for treatment of co-occurring substance abuse and for use of psychiatric medications for individuals with co-occurring substance abuse.

DMH/ADPA Joint Policy Development:

The DMH Director co-chairs the California Co-occurring Disorders Joint Action Counsel (COJAC), a statewide committee with state and local membership comprising administrators and state regulators for publicly funded substance abuse and mental health programs. This Counsel sets statewide guidelines for integrated substance abuse treatment, including development of screening tools and outcomes measures.

Community Meth Taskforce:

DMH is an active participant in the Community Meth Taskforce, which is led by ADPA and the Office of AIDS Programs and Policies. This taskforce provides interdepartmental coordination for policies and services to address methamphetamine abuse.

EXHIBIT B

LOS ANGELES COUNTY – DEPARTMENT OF PUBLIC HEALTH

Issues to Consider Regarding the Transfer of Alcohol and Drug Program Administration (ADPA) from the Department of Public Health to Department of Mental Health

April 9, 2009

On October 7, 2008, the Board of Supervisors instructed the Chief Executive Office to develop recommendations to the Board regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health (DPH) to the Department of Mental Health (DMH).

This paper outlines the program, policy, financial and service issues related to the concept of consolidating substance abuse and mental health services into a single agency.

EXECUTIVE SUMMARY

The potential benefits of consolidating ADPA with DMH need to be weighed against the following:

1) The low likelihood of significant program integration due to underlying distinctions in the fields of substance abuse and mental health which have remained in instances where consolidations have occurred;

2) The loss of integration with other DPH programs;

3) Financial and administrative implications; and

4) The potential to achieve improved substance abuse and mental health program integration via Memorandum of Understanding(s) between DPH and DMH, with review by the CEO.

Overall, the benefits of consolidation are not apparent. Moreover, the consequences of consolidation may diminish the priority given to substance abuse, and likely not yield appreciable cost savings or efficiencies of scale and will likely have a marginal negative impact on DPH costs.

PROGRAM AND POLICY ISSUES

Both substance abuse and mental health services share the underlying goal of improving human potential and function. However, there are distinct differences in the content, scope and approach that each contributes to the accomplishment of this goal.

The variation in approach and scope reflect the underlying differences in the causes of the conditions and the solutions that are employed to address substance abuse and mental illness. These differences affect program design, personnel skills, and the scope and variety of treatment and recovery services available.

Many substance abuse treatment models have their origins in community recovery movements, involving rehabilitation with a supportive community of peers. Substance abuse treatment agencies often include staff with experience-based rather than formal training. In contrast, mental health agencies typically emphasize a professional tradition of formal training and credentialing in academic departments of psychiatry, psychology, and social work. These distinctive backgrounds have led to differences in treatment philosophies and training which have been documented as resulting in distrust of treatments by substance abuse and mental health providers[1].

Prevention

DMH focuses primarily on the provision of a spectrum of mental health treatment services to individuals in Los Angeles County. Although ADPA contracts for an array of substance abuse treatment services, its focus on population-level substance abuse prevention is equally important. Substance abuse prevention entails a number of elements including addressing individual and community risk factors. ADPA collaborates with other DPH programs and community partners in assuring the implementation of a robust prevention program. The Methamphetamine Workgroup (discussed below) is an example of its prevention work.

Prevention is a core function for DPH and substance abuse prevention is a core mission of ADPA. If ADPA were transferred, given DMH's size and the primacy of its treatment focus, it is unlikely that a focus on prevention would be given priority. This would result in the loss of the important opportunity to reduce demand for substance abuse treatment services. In a jurisdiction where substance abuse and mental health services have been merged, the larger mental health agency focused on mental health early intervention services; at the same time substance abuse prevention services diminish as a priority[2].

Staff Implications

Staffing costs would not necessarily decrease because substance abuse personnel and mental health personnel are not interchangeable, and the loss of substance abuse staff expertise may occur. Alcohol and other drug services providers are frequently certified counselors who bring life experience and sometimes a history of recovery to their work. In contrast, mental health services are principally comprised of licensed professionals with graduate degrees. This results in different salary structures, training and certification needs. In states where substance abuse and mental health agencies have been merged, key stakeholders and directors reported loss of key substance abuse staff, difficulty in staff recruitment and retention[3].

Many substance abuse treatment models have their origins in community recovery movements, involving rehabilitation with a supportive community of peers. Substance abuse treatment agencies often include staff with experience-based rather than formal training. In contrast mental health agencies have a professional tradition of formal training and credentialing in psychiatry, psychology, and social work. The resulting differences in treatment philosophies and training have been documented as resulting in distrust of treatments by substance abuse and mental health providers[4].

Linkage to Other Public Health Priorities

Substance abuse contributes to a constellation of risks requiring a comprehensive and coordinated approach to effectively reduce disease and injury morbidity and mortality. The need for coordination among related public health programs is critical. For example, transferring APDA would separate it from the Tobacco Control Program. Both programs focus on the prevention and control of addictive substances that result in significant morbidity and mortality.

In addition, the role of substance abuse in increased STD and HIV risk behaviors has resulted in cross-training and collaboration among DPH programs. Specifically, part of the Federal funds received from California Alcohol and Drug Programs Substance Abuse and Treatment Block Grant (SAPT) require that a minimum amount be targeted toward services for individuals affected by HIV and TB and need to include counseling and education on HIV and TB, risks of needle sharing, risks of transmission to sexual partners and infants, preventive steps to ensure that HIV transmission does not occur as well as referral for HIV and TB treatment

Another area is methamphetamine use which presents an unprecedented challenge to the health and welfare of Los Angeles County residents. The Methamphetamine Prevention and Treatment Plan, Methamphetamine Workgroup, and resulting programs and services rely on close collaboration between ADPA, the Office of AIDS Programs and Policy, the Sexually Transmitted Disease Control Program and representatives from community- based agencies and other County departments. The transfer of ADPA to DMH would diminish this comprehensive approach.

Surveillance and Assessment

Increasingly ADPA activities are linked to DPH surveillance and assessment functions to produce high-quality and comprehensive health data about both clients and the Los Angeles County population to understand demand for services, inform planning, and evaluate program and service effectiveness. ADPA also uses surveillance and assessment data to understand trends in substance use beliefs, risk behaviors, substance use, and service utilization to guide its program development and evaluate assessment of program and service effectiveness. These activities are facilitated and supported by DPH's Health Assessment and Epidemiology Program as well as extensive collaboration with university substance abuse center researchers.

These population-level surveillance and assessment activities are crucial to assure the best use of limited substance abuse funds. ADPA's location in DPH facilitates its linkage to the LA Health Survey and participation in public health surveillance activities. In addition, other DPH programs are able to utilize substance abuse-related data allowing them to plan for their populations in a more comprehensive manner. Although a transfer would not preclude ADPA from participating in the LA Health Survey, this process could become more complex with no appreciable benefit to DMH or APDA.

FISCAL AND ADMINISTRATIVE ISSUES

In addition to the significant programmatic differences discussed above, considerable fiscal and administrative issues must be examined when considering the benefit of transferring ADPA to DMH.

Implications to DPH Finances

The transfer of ADPA to DMH will impact the administrative and fiscal structure of DPH. ADPA currently supports $1.8 million of administrative cost to DPH. This would further impact DPH's administrative capacity which was recently supplemented with additional items in recognition of the comparative understaffing in these areas when compared to other organizations. The funds provide support for administrative services for personnel services, financial and contractual services, legal assistance and information technology services. Transfer of ADPA would result in a loss of funds that support shared administrative costs which will not be proportionately reducible such as certain finance and administrative functions performed at the DPH level. To the extent this occurs, other funding, including net County cost, may be required to backfill the loss of ADPA funds.

Additionally, because ADPA and DMH have few funding mechanisms in common, there would be a need to coordinate funding as occurs today, and combining the two agencies would not result in significant increased efficiencies in financial management. It is important to note that even in the area of co-occurring disorders, mental health and substance abuse funding streams differ. Consequently, DMH and ADPA would still need to comply with different program conditions and requirements regardless of a transfer and it would be necessary to implement the same coordination/integration work regardless of where ADPA was placed.

Contract Administration Savings May Be Highly Unlikely

Although ADPA and DMH contract with some of the same service providers, the savings that may be associated with merging contract administration are uncertain. It is estimated that ADPA and DMH have 43 contract agencies in common. This compares to the 206 contract agencies overall in the ADPA network.

However, there are distinct differences between the contract portfolios of the two agencies. Despite a shared need for clinical treatment contractors, DMH and ADPA contract for a different spectrum of services. Specifically, ADPA has a significant number of prevention and non-clinical treatment contracts that would be maintained and added to DMH's current contract portfolio if the transfer were implemented.

Management and monitoring of ADPA and DMH contracts would require dual expertise on the part of contract management staff. Two sets of personnel would be needed: one with expertise in mental health and the other in substance abuse. ADPA and DMH have different types of contracts, stemming from different state/federal funding sources, each with specific programmatic, monitoring and reporting requirements. It is highly unlikely that any economies of scale would be gained combining these two vastly different contract portfolios.

SERVICE DELIVERY ISSUES

ADPA and DMH serve distinct and, at times, overlapping populations. Based on national estimates, less than 9% of the general population has been treated for both mental health and substance use disorders[5]. Research indicates that estimates of those in treatment with co-occurring disorders vary depending on the methods of measurement used[6]. However actual data from clients treated for substance abuse at Antelope Valley Rehabilitation Center in FY 2007-08 indicated that 15% had taken prescribed medication for mental health needs in the past 30 days[7]. In this case, the remaining 85% of patients required substance abuse services.

In considering the benefits of transferring ADPA to DMH it must be acknowledged that the majority of individuals do not have co-occurring disorders. The decision to merge the two agencies must weigh the benefit of this option of achieving integrated services for individuals with co-occurring disorders against the potential disruption to both agencies which serve a larger population of individuals with substance abuse or mental health disorders.

ADPA and DMH have different service delivery models. DMH uses primarily a clinical services model. ADPA on the other hand relies on a combination of peer support, self-help, social model and clinical interventions. Reports indicate that substance abuse agencies are often given lower priority when subsumed by much larger mental health agencies.[8] A merged mental health/substance abuse agency could result in a tiered system in which the clinical model services are favored over social model programs and services. The disparities in the size of the two organizations would enhance this effect.

Service Delivery for Co-occurring Populations

Both ADPA and DMH acknowledge the need for an integrated service approach to address the needs of individuals with co-occurring substance abuse and mental health disorders. One perspective holds that the transfer of ADPA is an approach to accomplish this. The other perspective holds that improved service integration can be

accomplished without the transfer, a view supported by a 2007 report from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Systems integration is viewed as a method of increasing access to and effectiveness of treatment of individuals with co-occurring substance abuse and mental health disorders. However, systems integration, while facilitating service integration, does not require the organizational merging of departments or programs. The 2007 SAMHSA report defined systems integration as, "The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families."[9] Moreover, the SAMHSA report further stated:

> *"Creation of an "integrated" State mental health and substance abuse department is in no way synonymous with systems integration. Depending on the system, creation of an integrated mental health and substance abuse department may provide a starting place for the organized integrated planning and implementation efforts that are requisites for systems integration. Alternatively, such a merger may create resistance within the existing systems that actually impedes the operationalization of systems integration efforts."*

Systems integration to provide optimal services to individuals with co-occurring disorders is possible if both DPH and DMH work together to create and implement appropriate programs and services. Below are characteristics identified by SAMHSA that promote systems working in an integrated manner:

- Committed leadership;
- Integrated system planning and implementation;
- Value-driven, evidence-based priorities;
- Shared vision and integrated philosophy;
- Dissemination of evidence-based technology to define clinical practice and program design;
- True partnership among all levels of the system; and,
- Data-driven, incentivized and interactive performance improvement processes.

Current Collaboration and Future Opportunities

ADPA and DMH are currently involved in 14 collaborative projects. The collaboration between the two organizations is established via an administrative agreement. Nine projects are delivered though DMH and five through ADPA for a total of $1,720,000. Eight of these programs provide service to clients with dual diagnoses or co-occurring disorders; four programs treat clients in crisis; and a final project funds an annual co-occurring disorders conference. It is imperative that these collaborations be extended to provide better integrated services for the co-occurring population at AVRC and to assure linkages to comprehensive services individuals with co-occurring disorders regardless of the initial point of intake.

Service collaboration and integration can be expanded and deepened between DPH and DMH via Memorandum of Understanding (MOU), with review by the CEO. The MOU approach yields results. DPH's current MOU with the Department of Health

Services has maintained and strengthened the relationships and collaboration between the two departments. The Leavey Center MOU for the provision of comprehensive services to homeless individuals is another example of DPH's involvement in a collaboration to provide integrated to a vulnerable population.

An MOU between DPH and DMH would not only facilitate the development and implementation of a set of integrated services for those with co-occurring disorders, but would also set the groundwork for additional collaboration between the two departments. As the reports discussed above indicate, the most important factors in establishing successful integrated services for those with co-occurring disorders is commitment from all parties.

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[1] M. Audrey Burnam and Katherine E. Watkins. Substance Abuse With Mental Disorders: Specialized Public Systems And Integrated Care. Health Affairs, May/June 2006; 25(3): 648-658.

[2] State Substance Abuse Agencies and Their Placement Within Government: Impact On Organizational Performance And Collaboration In 12 States, A. Gelger, D. Rinaldo, The Avis Group, November, 2005.

[3] See "1" above.

[4] M. Audrey Burnam and Katherine E. Watkins. Substance Abuse With Mental Disorders: Specialized Public Systems And Integrated Care. Health Affairs, May/June 2006; 25(3): 648-658.

[5] Center for Substance Abuse Treatment. The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

[6] Center for Substance Abuse Treatment. The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

[7] Los Angeles County, Department of Public Health Alcohol and Drug Program Administration Los Angeles County Participant Reporting System (Antelope Valley Rehabilitation Center Data) FY 2007-2008.

[8] State Substance Abuse Agencies and Their Placement Within Government: Impact On Organizational Performance And Collaboration In 12 States, A. Gelger, D. Rinaldo, The Avis Group, November, 2005.

[9] Center for Substance Abuse Treatment. Systems Integration. COCE Overview Paper 7. DHHS Publication No. (SMA) 07-4295. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

EXHIBIT C

ALCOHOL AND DRUG PROGRAM ADMINISTRATION
DEPARTMENT OF MENTAL HEALTH
FUNDING ANALYSIS
FISCAL YEAR 2008-09

FUNDING TO MENTAL HEALTH

	FISCAL YEAR 2008-2009			
	DESCRIPTION	MOS	DSO #	BUDGETED AMOUNT
1	Behavioral Health Services (BHS)	Dual Diagnosis Services	09MH0025	$ 125,000
2	Los Angeles Men's Place (LAMP) Contract	Provide support svcs. And housing for chronically homeless persons who are dual and multi-diagnosed with mental illness.	09MH0021	50,000
3	UCLA Extension Dual Diagnosis Training	Ten weeks course on co-occurring disorder, consisting of three distinct classes: Fundamentals, Biological perspective, Socio-cultural issues on co-occurring disorders.	09MH0022	22,000
4	AB 2034 Short Term Housing - Homeless	Provide short term shelter, beds for homeless clients	09MH0023	112,000
5	SAMI Peer Advocate Training	Peer Advocate Training	09MH0020	19,000
6	Social Model Recovery	Social Model Recovery	09MH0018	419,000
7	DMH Dual Diagnosis Coordinator	Dual Diagnosis Coordinator	09MH0019	54,000
8	Dual Diagnosis Program	Dual Diagnosis Services	09MH0024	361,000
9	Annual Co-Occurring Disorders Conference	Annual Co-Occurring Disorders Conference	09MH0026	25,000
	TOTAL			$ 1,187,000

FUNDING FROM MENTAL HEALTH

	FISCAL YEAR 2008-2009			
	DESCRIPTION	MOS	DSO #	BUDGETED AMOUNT
1	MHSA-Psych. Emerg. (Tarzana Treatment Center)	Community Assessment Service Center services (CASC)	09PG0012	$ 175,000
2	MHSA-Psych. Emerg. (Didi Hirsch Psychiatric Service)	Community Assessment Service Center services (CASC)	09PG0013	175,000
3	Dual Diagnosis (BHS)	Residential Services	09PG0009	120,000
4	Dual Diagnosis (LACADA)	Residential Services	09PG0010	38,000
5	Dual Diagnosis (Tarzana Treatment Center)	Outpatient Drug Court Counseling services	09PG0011	25,000
	TOTAL			$ 533,000

EXHIBIT D

2004-05 GRAND JURY REPORT

Excerpt, pages 33 – 37 of the 2004-05 Grand Jury Report regarding the Placement of Alcohol and Drug Program Administration.

Table 1.3

Co-Occurring Mental Health, Physical Health and Substance Abuse Diagnoses in the DMH High Utilizer Population FY 2002-03

Health Diagnosis	Mental Health Diagnosis: Bipolar Disease	Schizo-phrenia	Major Depression	Psychosis	Others	Total
Hypertension	49	71	245	2	24	391
COPD*	28	32	77	-	19	156
Diabetes	33	58	166	2	19	278
Others	460	586	1,354	14	465	2,879
Subtotal	570	747	1,842	18	527	3,704
Substance	333	520	612	6	265	1,736
Total	903	1,267	2,454	24	792	5,440
Sample Size	5,440	5,440	5,440	5,440	5,440	5,440
% w/Health	10.5%	13.7%	33.9%	0.3%	9.7%	68.1%
% w/Substance	6.1%	9.6%	11.3%	0.1%	4.9%	31.9%
% w/Both	16.6%	23.3%	45.1%	0.4%	14.6%	100.0%

Source: Department of Mental Health Study

As shown in the table, 68.1% of this subgroup of DMH clients also had primary physical health diagnoses that were being treated by the Department of Health Services. The remaining 31.9% also had primary substance abuse treatment diagnoses and were receiving services funded by ADPA. In total, DMH estimated that nearly $300 million in services were being provided to the "high utilizer" patient population in FY 2002-03.

Although only 31.9% of "high utilizer" DMH patients were also identified as having a primary substance abuse diagnoses, this percentage may not fully describe the degree to which mental health clients require substance abuse treatment. Although we were not provided data to support his assertion, the Mental Health Director has suggested that "probably 60 percent to 80 percent of *all* mental health clients also exhibit some form of drug or alcohol dependency."[9] Like the "high utilizer" population, many of these "dual diagnosed" patients receive services from both DMH and from contractors funded by the Alcohol and Drug Program Administration section of the DHS Public Health Division.

[9] This assertion has been challenged by DHS, who believe that the percentage of patients with co-occurring mental health and substance abuse diagnoses may range closer to 5% to 10% of the total DMH population.

There has been much controversy within the mental health and substance abuse communities regarding the relationships between the two populations of clients. During interviews we were advised that substance abuse clients generally do not want to be "stigmatized" by being associated with mental illness. On the other hand, mental health clients and their families see mental illness as a disease which encompasses much more than the substance abuse issues that are presented by the patients. Despite these perceptions, government agencies have been moving toward combined "behavioral health" organizations in recent years in an attempt to merge the two closely related services.

As the Board of Supervisors considers the County's healthcare organization after the creation of a health authority, it should examine the possibility of moving the Department of Mental Health and Alcohol and Drug Administration Program into a combined Behavioral Health Agency structure. This structure would provide opportunities to enhance interaction between the two services.

SUMMARY OF ORGANIZATIONAL ALIGNMENT FACTORS

Based on the analysis previously presented, DHS' hospitals, comprehensive health centers and other ambulatory care clinics should be transferred to the health authority. The responsibility for all other functions reviewed as part of this study should be retained by the County, including managed care, core public health, emergency medical services, juvenile court services, alcohol and drug treatment and mental health treatment services. The County should also look for opportunities to better align those healthcare related services that it retains, as discussed in this report.

Table 1.4

Organization Planning Matrix for Aligning Health Related Functions in Los Angeles County

	Primary Mission			Client Base			Preferred Alignment	
Program	Public Health	Physical Health	Behavioral Health	General County	Uninsured/ Indigent	Other	County	Health Authority
Hospitals		X			X			X
Ambulatory Care		X			X			X
Managed Care		X				X	X	
Core Public Health	X			X			X	
Emergency Medical Services		X		X			X	
Juvenile Court Services		X				X	X	
Alcohol & Drug Treatment			X			X	X	
Mental Health Treatment			X			X	X	

By aligning services in this manner, the health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding the current role to include health authority monitoring functions, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice and welfare.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the authority's statutory mandate.

Currently, the staff assigned to health services administration functions within DHS are shared by the programs some of which would be separated from the County when the health authority is created. As a result, decisions will need to be made regarding the allocation of administrative personnel and other resources between the health authority and the DHS divisions that remain as part of the County organization. The Board of Supervisors should direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of personnel and resources as part of a health authority transition plan.

CONCLUSIONS

Several proposals to create a Los Angeles County health authority have been made over the past ten to fifteen years. However, the health services components included in each proposal have differed greatly and have been vaguely defined.

Previous proposals have not fully addressed whether responsibilities related to mandated Public Health or Mental Health services should be retained by the County or absorbed by the health authority. Further, these proposals have not consistently answered critical questions related to the complex responsibilities for providing indigent medical care services defined by California Welfare and Institutions Code Section 17000, case law and policy of the Board of Supervisors.

Before considering the complex governance, operational, funding or legal questions associated with the creation of an independent health authority, the Board of Supervisors, with input from DHS and the County's healthcare community, should clearly define the health authority's mission and functional components. A preferred model would transfer authority and responsibility for all physical health services to the health authority; would charge the health authority with the responsibility to provide specified levels of healthcare services to the uninsured and indigent; and, establish emergency and acute psychiatric care services in hard to serve areas of the County. Public Health services, Emergency Medical Services and other broad regulatory or coordination functions, should be

retained by the County. The Department of Mental Health should remain an independent County department that is separate from the health authority.

RECOMMENDATIONS

The Board of Supervisors, with input from DHS and the County's healthcare community, should:

1.1 Develop a clearly defined mission for the new health authority that is focused on the delivery of safety net physical health services for the uninsured and indigent populations within Los Angeles County.

1.2 Clearly define the minimum level of service to be provided by the health authority, based on Welfare and Institutions Code §17000 and case law.

1.3 Develop a structure that retains the County's responsibility for providing public health, mental health, drug and alcohol, emergency medical, managed care and juvenile court health services.

The Board of Supervisors should:

1.4 Retain the Department of Mental Health as a distinct County department not under the jurisdiction of the new health authority.

1.5 Establish Public Health as a distinct County department not under the jurisdiction of the new health authority.

1.6 Consider placing the Emergency Medical Services function under the authority of the Public Health Officer.

1.7 Consider placing Managed Care under the authority of the Public Health Officer, and expanding its role to include the monitoring of health services provided by the health authority under its contract with the Board of Supervisors.

1.8 Consider placing the Alcohol and Drug Program Administration function under the Department of Mental Health and creating a Behavioral Health Department.

1.9 Retain responsibility for health services functions provided to juveniles who are in County institutions (Juvenile Court Services), but contract with the health authority or another provider to provide such services.

1.10 Direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of DHS Health Services Administration personnel and resources as part of a health authority transition plan.

COSTS AND BENEFITS

There would be no direct cost to implement these recommendations. However, staff time would be required to provide the analyses that will be necessary for the Board of Supervisors to make informed decisions.

The health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding its current role, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, the behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the Authority's statutory mandate.

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

State of California – California Health & Human Services Agency *http://www.chhs.ca.gov/Pages/default.aspx*	
Department of Health Care Services *http://www.dhcs.ca.gov/Pages/default.aspx*	▪ California Children's Services ▪ Child Health and Disability Prevention ▪ Children's Medical Services

Department of Public Health
http://www.cdph.ca.gov/Pages/default.aspx
	▪ External Affairs
	  ▪ Binational Border Health
	  ▪ Legislative and Governmental Affairs
	  ▪ Multicultural Health
	  ▪ Public Affairs
	  ▪ Women's Health
	▪ Policy and Programs
	  ▪ Coordinating Office for Obesity Prevention
	  ▪ Emergency Preparedness Office
	  ▪ Health Information and Strategic Planning
	  ▪ State Laboratory Director
	▪ Center for Chronic Disease and Health Promotion
	  ▪ Center for Chronic Disease and Health Promotion
	  ▪ Chronic Disease and Injury Control
	  ▪ Environmental and Occupational Disease Control
	▪ Center for Environmental Health
	  ▪ Center for Environmental Health
	  ▪ Drinking Water and Environmental Management
	  ▪ Food, Drug, and Radiation Safety
	▪ Center for Family Health
	  ▪ Center for Family Health
	  ▪ Family Planning
	  ▪ Genetic Disease Screening Program
	  ▪ Maternal, Child, and Adolescent Health
	  ▪ Women, Infants, and Children

Department of Public Health *continued*
http://www.cdph.ca.gov/Pages/default.aspx
	▪ Center for Healthcare Quality
	  ▪ Center for Healthcare Quality
	  ▪ Laboratory Field Services
	  ▪ Licensing and Certification
	▪ Center for Infectious Disease
	  ▪ Center for Infectious Disease
	  ▪ AIDS
	  ▪ Communicable Disease Control

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Department of Alcohol and Drug Programs *http://www.adp.ca.gov/*	The **Department of Alcohol and Drug Programs** is responsible for administering prevention, treatment, and recovery services for alcohol and drug abuse and problem gambling. ▪ Treatment ▪ Resource Center ▪ Youth Services ▪ Women's Programs ▪ Problem Gambling ▪ Driving Under the Influence Programs ▪ California Access to Recovery Effort (CARE) ▪ Co-Occurring Disorders
Department of Mental Health *http://www.dmh.cahwnet.gov/*	California's public mental health system offers an array of community and hospital-based services that are available to adults who have a serious mental illness and children with a severe emotional disorder. ▪ Rehabilitation and support ▪ Evaluation and assessment ▪ Vocational rehabilitation ▪ Individual service planning ▪ Residential treatment ▪ Medication education and management ▪ Case management Groups ▪ Wrap-around services ▪ State Hospitals ▪ Forensic Programs ▪ Children & Youth Services ▪ Adult Services ▪ Quality Oversight

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Orange County – Health Care Agency *http://www.ochealthinfo.com/*	
Behavioral Health Services	Culturally-competent and client-centered system of behavioral health services for all eligible county residents in need of mental health care and/or treatment for alcohol and other drug abuse. ▪ Adult Mental Health Services ▪ Children and Youth Mental Health Services ▪ **Alcohol and Drug Abuse Services**
Medical & Institutional Health	Emergency medical care, medical and behavioral health care to adults and children in institutional settings, and contracted essential medical services for patients for whom the County is responsible. ▪ Health Disaster Management (HDM) ▪ Emergency Medical Services (EMS) ▪ Disaster Preparedness and Training ▪ Medical Reserve Corps (MRC) ▪ Institutional Health Services (IHS) ▪ Medical Services Initiative (MSI)
Public Health Services	Public Health Services monitors the incidence of disease and injury in the community and develops preventive strategies to maintain and improve the health of the public. Ensures food safety, water quality and protects the public's health and safety from harmful conditions in the environment, from animal-related injury, and from disease and nuisance hazards through the enforcement of health and safety standards. ▪ California Children's Services ▪ Disease Control and Epidemiology ▪ Environmental Health ▪ Family Health ▪ Health Promotion ▪ Laboratory ▪ Nursing ▪ Public Health Administration ▪ Healthy Families Assistance Programs

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

San Bernardino County *http://www.co.san-bernardino.ca.us/*	
Department of Behavioral Health *http://www.co.san-bernardino.ca.us/dbh/*	Behavioral Health Programs strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities. ▪ Adult Services ▪ **Alcohol& Drug Services** ▪ Children Services ▪ Forensic Services ▪ Outpatient Services
Department of Public Health *http://www.sbcounty.gov/pubhlth/Default.aspx*	The Department of Public Health works to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote and encourage healthy behaviors, respond to disasters and assist communities in recovery, and assure the quality and accessibility of health services throughout the county. ▪ Public Health Clinics ▪ Preparedness & Response ▪ Animal Care & Control ▪ Nursing Services ▪ Environmental Health Services

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

Riverside County *http://www.countyofriverside.us/portal/page/portal/comew*	
Department of Mental Health *http://mentalhealth.co.riverside.ca.us/opencms/*	The Department provides effective and culturally sensitive community-based services that enable adults who are mentally disabled, adults who are older, children who are at risk of mental disability, substance abusers, and individuals who need conservatorship, to achieve their optimal level of healthy personal and social functioning. ▪ Adult Mental Health Services ▪ Older Adult Mental Health Services ▪ Children's Services ▪ Public Guardian ▪ **Substance Abuse Program**
Department of Public Health *http://www.rivcoph.org/*	The Department of Public Health promotes and protects the health of all County residents and visitors in service of the well-being of the community. ▪ Family Care Centers – Health Care ▪ Disease Control ▪ Maternal, Child & Adolescent Health ▪ Children's Medical Services ▪ Public Health Nursing ▪ Nutrition & WIC Services ▪ Health Promotion and Professional Development ▪ Public Health Laboratory ▪ Industrial Hygiene ▪ Emergency Medical Services ▪ Emergency Preparedness and Response ▪ Injury Prevention Services ▪ HIV/AIDS Program ▪ Medical Marijuana Identification Card ▪ Family Planning ▪ Epidemiology & Program Evaluation ▪ Vital Records ▪ Community Outreach

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

San Diego County – Health and Human Services Agency *http://www2.sdcounty.ca.gov/hhsa/*	
Behavioral Health *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=3*	Behavioral Health includes a continuum of services aimed at providing an array of mental health, alcohol and other drug services for children, youth, families, adults, and older adults, and improving the quality of life within communities. Behavioral health services include prevention, treatment, and interventions that promote recovery and social well-being. ▪ **Alcohol and Drug Services (ADS)** ▪ Adolescent Treatment Services – non residential ▪ Adolescent Treatment Services – residential ▪ Adult Treatment Services – non residential ▪ Adult Treatment Services – residential ▪ Adult Treatment Services – Detox ▪ Driving Under the Influence Program ▪ HIV Counseling and Testing ▪ Methamphetamine Strike Force ▪ PC 1000 Program/AIDS Education ▪ Prevention Services ▪ Inpatient Health Services ▪ Mental Health Services – Adult and Older Adult ▪ Mental Health Services – Children
Behavioral Health *continued* *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=3*	
Public Health *http://www2.sdcounty.ca.gov/hhsa/programs ervices.asp?ProgramID=4*	Public Health Services is dedicated to community wellness and health protection. Public Health Services works to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote and encourage healthy behaviors, respond to disasters and assist communities in recovery and assure the quality and accessibility of health services. ▪ Black Infant Health Program ▪ Border Health Program ▪ Child Health and Disability Prevention Program ▪ Childhood Lead Poisoning Prevention Program ▪ Chronic Disease and Health Disparities ▪ Community Epidemiology ▪ Community Health Statistics ▪ Comprehensive Perinatal Services Program ▪ CureTB: Binational TB Referral Program ▪ Dental Health Initiative/Share the Care ▪ Emergency Medical Services ▪ HIV, STD and Hepatitis Branch ▪ Immunization Branch ▪ Maternal, Child and Family Health Services ▪ Office of Violence Prevention ▪ Office of Vital Records and Statistics

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

	▪ HIV/AIDS Epidemiology Unit ▪ Public Health Laboratory ▪ Public Health Nursing ▪ Tobacco Control Resource Program ▪ Tuberculosis Control Program
Ventura County - Health Care Agency *http://portal.countyofventura.org/portal/page?_pageid=953,1&_dad=portal&_schema=PORTAL*	
Behavioral Health *http://portal.countyofventura.org/portal/page?_pageid=953,1293790&_dad=portal&_schema=PORTAL*	The Behavioral Health Department is dedicated to relieving suffering and enhancing recovery from mental illness, alcohol and other drug problems, through leadership in education, training, service, and policy advocacy. ▪ **Alcohol and Drug Programs** ▪ Children's Services ▪ Adult Services ▪ Quality Improvement ▪ Mental Health Services Act (MHSA) ▪ Drinking Driver ▪ Crisis Team ▪ Managed Care
Public Health *http://portal.countyofventura.org/portal/page?_pageid=953,1293789&_dad=portal&_schema=PORTAL*	The Department of Public Health's goals are to prevent illness, injuries and the spread of disease, assure highest quality and accessible health services, promote and encourage healthy behaviors, and to respond to disasters and assist communities in recovery. ▪ Children's Health Care ▪ Flu Clinics ▪ Disease and Control Prevention ▪ Community Nursing and Health Education ▪ Family Health ▪ Emergency Preparedness

EXHIBIT E

Placement of Alcohol and Drug Programs in the State of California and Surrounding Counties - Survey

	Alcohol & Drug Programs *(As its own Department)*	Department of Behavioral Health	Department of Mental Health	Department of Public Health
LA County				√
State of California	√			
Orange County		√		
San Bernardino County		√		
Riverside County			√	
San Diego County		√		
Ventura County		√		

California Performance Review

HHS15 Consolidate the State's Mental Health and Alcohol and Drug Programs to Better Serve Californians

Summary

California administers its alcohol, drug and mental health programs in two separate agencies. Consolidating the management of these behavioral health programs will improve coordination of county administered services to persons suffering from both mental illness and substance use disorders.

Background

California's alcohol and drug programs are administered by the Department of Alcohol and Drug Programs (ADP) with most services operated by or through counties. California's mental health programs are administered by the Department of Mental Health (DMH).

For Fiscal Year 2004-2005, ADP is budgeted for 356 positions to administer approximately $591 million in total funds. DMH is budgeted for 9,183 positions to administer approximately $2.5 billion to fund the state hospitals and community services. Within DMH are 318 headquarters positions not directly related to state hospital operations to administer approximately $1.8 billion in total community services funds.[1] Virtually all community mental health services are delivered by or through counties in concert with more than $650 million in mental health funds which go directly to counties rather than through the DMH budget.[2]

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports that more than half the people diagnosed with a mental disorder also have an alcohol or other drug-related disorder, and of those persons diagnosed with serious mental illness, 41 percent have alcohol or other drug disorders.[3] Persons suffering from serious and persistent mental illness who are involved with the criminal justice system have been estimated to have co-occurring substance abuse disorders at rates as high as 82 percent.[4] According to SAMHSA, "The most common cause of psychiatric relapse today is use of alcohol, marijuana, and cocaine. The most common cause of relapse of substance use/abuses today is untreated psychiatric disorder."[5]

Inadequate and ineffective treatment of substance abuse and mental illness not only destroys lives, but also manifests in costs and problems in virtually all government programs including health care, education, housing/homelessness and particularly adult and juvenile justice systems. Experience with treating persons diagnosed with both mental illness and substance abuse disorders-known as co-occurring disorders-indicates that merging treatments produces better results.[6]

The Substance Abuse and Mental Health Services Administration recently completed the first in a series of policy reviews on co-occurring disorders. According to SAMHSA Chief of Staff Gail Hutchings, there was clear consensus from behavioral health officials representing ten states that integrated treatment is the preferred option for persons with co-occurring disorders.[7] However, many people in the addiction field fear that merging addiction and mental health responsibilities will reduce the visibility of alcohol and drug treatment and prevention.[8]

Over the last twenty years, public mental health treatment in California has been moving from a "medical model" in which decisions were made exclusively by professional treatment staff- primarily psychiatrists and psychologists-to a "recovery model" in which the consumer participates fully in treatment planning and implementation. The mental health recovery approach is becoming increasingly like that employed by alcohol and drug treatment programs. At the same time, the alcohol and drug abuse treatment field is becoming more professional with greater certification of treatment providers and staff. The increasing similarities in the treatment approaches, however, are not fully understood or appreciated by the two disciplines.

While alcohol and drug programs include an effective focus on prevention, mental health has not developed a useful prevention strategy. Public mental health treatment programs have greatly increased involvement of consumers and family members in all aspects of program administration. Mental health treatment is generally regarded as employing a systems approach while alcohol and drug services have evolved more as a collection of services. Each system could benefit from association with the other. Robert Nikkel, Administrator of Oregon's Office of Mental Health and Addiction Services, reports that placing both functions together in Oregon was disruptive at first, but has produced considerable benefit for both service systems over time.[9]

Twenty-five other states have merged their mental health and substance abuse program functions. The National Association of State Mental Health Program Directors (NASMHPD) reports that while the reorganization trend of the 1980s and early 1990s split mental health and substance abuse services, the trend now appears to be moving toward consolidating both functions into the same agency.[10]

Thirty-eight California counties have merged local departments dealing with mental health and substance abuse.[11] While most counties that have merged alcohol and other drug (AOD) and mental health (MH) responsibilities report improved services to persons dually diagnosed with mental illness and substance abuse disorders, counties struggle to employ expensive "work arounds" in which a great deal of administrative work is done to ensure proper bookkeeping to integrate mental health and substance abuse services. Two counties-San Bernardino and Stanislaus-report keeping two sets of books to overcome some of the obstacles created by separate state operations.[12] San Francisco County reports its biggest administrative challenge may well be relating to two separate and unconnected departments at the state level.[13]

Monterey County is reportedly better able to serve Temporary Assistance for Needy Families (TANF) referrals since they merged their systems in 1996.[14] Stanislaus County has integrated its service teams to include AOD and MH specialists without "homogenizing," but instead, emphasizing the unique clinical strategies and values of each field. Clients enter the same door, and when receiving both AOD and MH services, are tracked in one chart.[15] Alameda County reports significant benefit from having previously separated program management staff sitting at the same table helping each other solve problems while gaining better understanding and appreciation of each other's professional culture.[16] San Francisco reports developing a number of highly effective combined programs, such as multiple diagnosis medically supported detox, dual diagnosis residential programs, dual diagnosis outpatient care, and providing substance abuse medication protocols to mental health physicians.[17] No county responding to the question of potential for loss of emphasis on AOD services reported any such loss.

Recommendation

A. The Health and Human Services Agency, or its successor, should consolidate the administration of the state's substance abuse and mental health programs.

Fiscal Impact

Savings of approximately $1.8 million annually should accrue from elimination of duplicate functions and staff. At a minimum, the following positions should be eliminated: one director, one chief deputy director, one chief counsel, one public information officer, one deputy director/chief of legislation, one deputy director for administration, one deputy director/chief of information technology.

In addition, 10 percent of the Department of Alcohol and Drug Program administrative services and 5 percent of the Department of Mental Health administrative services could be eliminated. The reason for reducing DMH administrative services by only 5 percent presumes that the Department of Behavioral Health would continue to operate the state hospital system.

TOTAL FUNDS (dollars in thousands)

Fiscal Year	General Fund Savings	Federal Fund Savings	Other Fund Savings	Total Net Savings	Change in PYs
2004-05	$0	$0	$0	$0	$0
2005-06	$180	$1,653	$20	$1,853	(10)
2006-07	$180	$1,653	$20	$1,853	(10)
2007-08	$180	$1,653	$20	$1,853	(10)
2008-09	$180	$1,653	$20	$1,853	(10)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003-2004 expenditures, revenues and PYs.

Endnotes

[1] California Department of Finance, "Governor's Budget 2004-2005," (Sacramento, California, January 2004). pp. HHS 21 and HHS 102.

[2] Interview with Stan Johnson, chief, County Financial Program Support, California Department of Mental Health, Sacramento, California (May 25, 2004).
[3] Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" (Rockville, Maryland, 2002), p. 1.
[4] California Board of Corrections, "Mentally Ill Offender Crime Reduction Grant Program Annual Legislative Report" (Sacramento, California, 2002), p. 2.
[5] Substance Abuse and Mental Health Services Administration, "Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders" (Rockville, Maryland, January, 1997), p. 1.
[6] Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorder" (Rockville, Maryland, 2002), p. 15.
[7] E-mail from Gail P. Hutchings, M.P.A., chief of staff, Substance Abuse and Mental Health Services Administration, to California Performance Review (May 17, 2004).
[8] Interview with Toni Moore, administrator, Sacramento County Alcohol and Drug Program Administration, and Patrick Ogawa, director, Los Angeles County Alcohol and Drug Program Administration, Sacramento, California (March 16, 2004).
[9] E-mail from Robert Nikkel, administrator, Oregon Office of Mental Health and Addiction Services, to California Performance Review (May 10, 2004).
[10] National Association of State Mental Health Program Directors Research Institute, Inc., "State Mental Health Agency Organization and Structure: 2003," No. 03-10 (Alexandria, Virginia, January 2004), pp. 1-2.
[11] Interview with Jim Featherstone, director, Napa County Mental Health, and Marvin Southard, DSW, director, Los Angeles County Department of Mental Health, board members, California Mental Health Directors Association, Sacramento, California (March 10, 2004).
[12] Interview with Larry Poaster, PhD, director, Stanislaus County Department of Behavioral Health, retired, Modesto, California (March 30, 2004); and interview with Rudy Lopez, director, San Bernardino County Behavioral Health, San Bernardino, California (April 9, 2004).
[13] E-mail from James Stillwell, program manager, San Francisco Behavioral Health, to California Performance Review (April 12, 2004).

[14] E-mail from Robert Egnew, director, Monterey County Department of Behavioral Health, retired, to California Performance Review (April 1, 2004).
[15] E-mail from Dan Souza, director, Stanislaus County Department of Behavioral Health, to California Performance Review (April 1, 2004).
[16] Interview with Marye Thomas, MD, director, Alameda County Behavioral Health, Oakland, California (April 8, 2004).
[17] E-mail from James Stillwell.

EXHIBIT G

CAADPE

CALIFORNIA ASSOCIATION OF ALCOHOL AND DRUG PROGRAM EXECUTIVES, INC.

William T. Fujioka
Los Angeles County, Chief Executive Officer
713 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

January 13, 2009

Dear Mr. Fujioka,

I am writing on behalf of California Association of Alcohol and Drug Program Executives, Inc. (CAADPE), Southern California Chapter in regards to Supervisor Antonovich's motion to consolidate the office of Alcohol and Drug Programs with the Los Angeles County Department of Mental Health.

It is our understanding this matter is currently under review by your office with a report due back to the Board of Supervisors in March, 2009. Consistent with your review efforts considering this matter, CAADPE wishes to meet and discuss the issue with you. We think it is imperative you take into account our perspective on this issue and that you consider and digest the enclosed attachments which address the notion of merging Mental Health and AOD Departments.

Attachments include:

1. Organizational Placement of State Substance Abuse Agencies: Impact on organizational performance
2. CADPAAC response to Health and Human Services Agency Stakeholder Survey – California Performance Review Recommendations
3. Analysis of CPR Recommendation to Consolidate Mental Health and Alcohol and Drug Programs
4. ACHSA Issues/Concerns Re: Potential Merger of ADPA with LACDMH

Assuming your willingness to meet, I will ask my office to contact your office to set up a time that works for both.

If you have any questions or require any further information, please contact me at 818-654-3815.

Respectfully,

Albert M. Senella
President CAADPE, Chair Southern CA Chapter

1127 - 11th Street, Suite 208, Sacramento, CA 95814
(916) 329-7409 FAX (916) 442-4616 caadpe@pacbell.net

ORGANIZATIONAL PLACEMENT OF STATE SUBSTANCE ABUSE AGENCIES:

IMPACT ON ORGANIZATIONAL PERFORMANCE

August 16, 2004

Report on Phase I Analysis

The Avisa Group
1117 Euclid Avenue
Berkeley, CA 94708

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BERKELEY, CA 94708

ACKNOWLEDGEMENTS AND METHODOLOGY

ACKNOWLEDGEMENTS

This study was performed by the Avisa Group on behalf of the California Department of Alcohol and Drug Programs (ADP). This study was supported by the Center for Substance Abuse Treatment (CSAT) State Systems Division, part of the Substance Abuse and Mental Health Services Administration (SAMHSA), through Contract No. 270-00-7071 with Health Systems Research, Inc (HSR). Terrence Schomberg, Ph.D. is the government project officer for this contract and William Ford, Ph.D., is the HSR project director for this study.

States were given an opportunity to review their own State descriptions and make comments and suggestions, many of which are incorporated here. In addition, senior staff of California ADP, William Ford, Ph.D. of HSR and three expert reviewers made comments and suggestions that are incorporated into this document. Remaining errors are the responsibility of the Avisa Group. The observations and views expressed herein are attributable to the Avisa Group and no endorsement by ADP, CSAT, SAMHSA or HSR is intended or should be inferred.

METHODOLOGY AND NEXT STEPS

Nine States were initially selected for inclusion in this phase of this qualitative study by California ADP and Avisa; these States were selected to represent different governmental organizational configurations and were selected from the nineteen most populous States because California is so large and diverse and comparisons to smaller states would not be appropriate. Structured interviews and follow-up discussions with State Directors and their key staff from each State Substance Abuse agency were conducted on site in three States: New York, Texas and Washington. In the other six States, structured interviews with Directors and their key staff were conducted by telephone. Additional information primarily related to expenditures was also requested from each State. A copy of the discussion guide used both in the telephone and the on-site interviews is appended.

An initiative to add three more States of interest, to conduct additional site visits and to add perspectives from other major constituents in each State has been

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approved by CSAT and is currently underway, with a final report expected in November 2004.

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EXECUTIVE SUMMARY

- State substance abuse services and policy are critical components of State government functions. Undetected, unprevented and untreated substance abuse problems impose significant costs on health care, on other State agencies and on other components of the community. States vary both in the extent of their substance abuse problem and in the prominence of their State substance abuse agencies within the State government.

- In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency because virtually every public agency has clients with substance abuse disorders.

- To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within an agency that does not fully share its priorities and mission.

- The organizational placement of a State substance agency is one major variable explaining the autonomy, visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or collaborative initiatives easily.

- One of the most important determinates of agency autonomy, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. Appointment of the State agency Director by the Governor confers authority, credibility and status, as well as clearly indicating the priority of substance abuse issues within State government.

- Substance abuse agencies that are in the lower echelons of the State bureaucracy and do not have sufficient visibility, adequate staff or other resources, report that they are simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, especially including criminal justice and law enforcement.

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- State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources reported being able to promote effective substance abuse policy through the agency's status, visibility, credibility with a strategy of interagency collaboration. These agencies also report being better able to devote internal resources to the effort required to obtain discretionary Federal funds.

- SSA's that are directly supported either by a drug Czar or where the SSA Director and staff have direct and positive relationships with the criminal justice/corrections system through other mechanisms also reported that they were better able to function efficiently and effectively as agencies.

- Several Directors and their executive staff emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. However, the exercise of any type of leadership requires resources.

- Substance use and abuse is an important issue in the treatment of those with severe mental illness (SMI) or severe emotional disorders (SED). Collaboration with the State substance abuse agency is of critical importance for State mental health agencies. Collaboration with the State mental health agency is a key function for State substance abuse agencies. However, treating co-occurring disorders is more of a programmatic and clinical issue than an organizational placement issue within state government.

- The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency or State government that the ability of the mental health agency to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control. However, the evidence developed to date in this nine State study clearly indicates that this submersion would significantly degrade the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to its collaboration with the mental health agency.

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FINDINGS

IMPORTANCE OF STATE SUBSTANCE ABUSE SERVICES AND POLICY

State substance abuse services and policy are critical components of State government functions. This is true despite the relatively small portion of State budgets devoted to substance abuse issues. Among the major sectors that are affected by substance abuse-related issues are public and private health care, public welfare and social services, public safety, accidents and violence, housing, education, adult and juvenile criminal justice and corrections, education, vocational rehabilitation, commerce/labor and economic development. Two clusters of issues explain the disparity between the critical importance of the issue of substance abuse to the States and the amount of direct spending by States on substance abuse education, prevention and treatment services.

First, undetected, unprevented and untreated substance abuse problems impose significant costs on health care and other components of the community[1], including:

1. Primary and specialty health care services and systems, especially including infectious disease and obstetrics
2. Public safety, violence and accidents
3. Child welfare
4. Criminal justice
    a. Law enforcement and the court system
    b. Jails, prisons and parole systems
    c. Juvenile justice
    d. Incarceration alternatives
5. Housing
6. Education and Vocational Rehabilitation
7. Mental health

Second, State substance abuse spending fluctuations, often related to budget deficits or surpluses, may be accompanied by corresponding changes in Federal support, causing a multiplier effect on State spending for substance abuse services. In addition, Federal Maintenance of Effort (MOE) requirements associated with the Substance Abuse Prevention and Treatment (SAPT) Block Grant stipulate that States must keep their State and/or county spending for

[1] Office of National Drug Control Policy (2001). *The Economic Costs of Drug Abuse in the United States, 1992-1998.* Washington, DC: Executive Office of the President (Publication No. NCJ-190636).

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substance abuse education, prevention and treatment at the previous year's level, no matter how large or small that level is, in order to retain the same level of Federal support. States failing to maintain their specified substance abuse State-funding levels are subject to a proportionate reduction in Federal funding under the SAPT Maintenance of Effort Requirements. Several States that Avisa examined have either been cited for MOE problems already or fear that they will be cited, causing fiscal uncertainty that affects planning, operations and interagency collaboration. Thus, reductions in State spending may incur a multiplier effect by causing a concomitant reduction in Federal spending.

Many States provide some substance abuse treatment services as an optional benefit under their Medicaid programs. State dollars spent for services covered by Medicaid are also matched according to a formula by Federal dollars, providing for a second multiplier effect that works in both directions. Therefore, spending by States for substance abuse education, prevention and treatment has an impact on health and welfare disproportionate to its size due both to the mechanisms of Federal support and to the corresponding impact of changes in spending on the direct and indirect economic and social costs of substance abuse and dependence. It is of note that both mechanisms of Federal support work to reduce Federal spending when State spending declines, but only Federal Medicaid support increases when State Medicaid expenditures increase.

ROLE OF COLLABORATION IN IMPLEMENTING SUBSTANCE ABUSE POLICY

In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required, according to all of the respondents interviewed. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency.

To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within another agency that does not fully share its priorities, requirements and mission. One of the most important determinates of autonomy and visibility, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. The State substance abuse agency must be perceived by other agencies and legislative/gubernatorial staff to have sufficient importance, status and clout within State government in order for them to be willing to spend scarce time, staff and effort at a time of competing

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priorities in effective collaboration. This makes it possible to develop and implement effective and efficient initiatives that maintain and optimize SA clinical service integrity and quality, while providing services to SA clients of other State departments. Attracting additional resources through active collaboration also provides the ability to devote resources to the effort required to obtain additional discretionary grant funds from Federal agencies that provide funding for substance abuse services, which in turn confers credibility with other State departments and the legislature.

This review of substance abuse agencies in nine large States indicated that SA agencies that lacked Gubernatorial appointment status, were in the lower levels of the State bureaucracy and did not have sufficient visibility, adequate staff or other resources, were simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, including criminal justice. One result was that these State substance abuse agencies appeared to be dominated by other constituencies such as providers and the substance abuse system responded primarily to the concerns and interests of these constituents rather than being able to focus more on the needs of the substance abuse clients and others negatively affected by substance abuse. The organizational placement of a State substance agency is one major variable explaining the visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or participate in and initiate collaborative efforts easily.

ORGANIZATIONAL PERFORMANCE OF STATE SUBSTANCE ABUSE AGENCIES

This study indicates that State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources report being able to promote effective substance abuse policy. This is accomplished through the agency's status, credibility and strategy of collaboration with other agencies throughout State government that enables the SSA to serve clients with substance abuse disorders who are often clients of other State systems. SSA's that were directly supported either by a cabinet-level drug Czar or where the SSA Director or staff have direct relationships with the criminal justice/corrections system through mechanisms, such as the SSA Director sitting on the State's drug demand reduction council or having professional experience in the criminal justice agency (CA, FL and MI), also reported that they were better able to

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function efficiently and effectively. A summary of these perceived organizational performance measures appears in Table I below.

TABLE I

PERCEIVED ORGANIZATIONAL PERFORMANCE

STATE	SSA DIRECTOR APPOINTED BY GOVERNOR	SUCCESS IN MOE	EXTENT OF COLLABORATION WITH OTHER AGENCIES	ABILITY TO MOUNT SA POLICY INITIATIVE
Florida	Y*	Y	H	H
Georgia	N	Y	L	L
Massachusetts[2]	N	N	L	L
Michigan	Y	Y[3]	H	H
New York	Y	Y	H	H
North Carolina	N	Y	H	M
Ohio	Y	Y	H	H
Texas[4]	N	Y	M	M
Washington	N	Y	H	H

N, Y No, Yes
H, M, L High, Medium, Low

* Director of Florida Office of Drug Control (ODC) appointed by Governor. Director of SSA, who is dually appointed to ODC and the State SA Agency, is not appointed by the Governor

SIGNIFICANT SUBSTANCE ABUSE POLICY ISSUES

State Directors and their staff raised a number of general substance abuse policy issues that were broadly relevant beyond the borders of their individual States. In addition to the specific organizational issues discussed in more detail in subsequent sections of this report, the following significant substance abuse policy issues were emphasized by State Directors:

[2] Massachusetts – Extensive collaboration and policy development within Department of Public Health, focused on prevention mission
[3] Michigan – Problems with MOE requirement prior to reorganization
[4] Texas - Planning for reorganization of State agencies has disrupted collaboration and SA policy development

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Leadership

- Several respondents emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. Although this attribution of the success of their agencies to the exercise of leadership by the Director and his/her key staff could be partly self-congratulatory, there appears to be a core of truth to this assertion.

- The exercise of any type of leadership requires resources. A Director and senior staff in an agency with severe resource constraints and very few staff members will be unable to devote the resources of the agency to leadership and interagency, intergovernmental activities. Even though such an agency could provide services to clients of many of these other departments, it will, instead, be forced to devote all available resources toward fulfillment of the agency's Federal and State required missions alone because of resource constraints. Although some of these missions require providing services to individuals who are also clients of other agencies, it is only the minimum number of required tasks that can be accomplished.

- The ability to exert leadership is fostered by staff and funding stability and continuity. Agencies with continuity in the positions of the Director and key staff, as well as having records of funding stability, report that they have more ability to be leaders in the State and in combating substance abuse.

- Policy leadership requires agency and staff collaboration with other entities, especially in SA, which provides services to many people who are also clients of other departments; effective inter-agency collaboration based on shared utilization and outcomes data is perhaps the most effective strategy to accomplish SA policy goals. However, collaboration requires funding and staff resources as well as autonomy, visibility and clout, in order to convince other State and community agencies to collaborate.

- Some respondents felt that reliance on personal leadership instead of organizational structure provided only a temporary solution to substance abuse policy imperatives when a longer term solution of structural autonomy was needed to assure effective State-funded substance abuse services.

Relationship to Mental Health Agency

- There are important differences between the substance abuse and mental health policy environments:

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- Mental health treatment is an entitlement for most individuals with severe mental illness. Departments of Mental Health aim to provide services to as many of these persons as possible because they are mandated to do so.

- In comparison, substance abuse treatment services are made available only to about twenty percent of those who are members of the substance dependent population, rather than to the entire target population.

- Substance abuse agencies and mental health agencies may be organizationally close to or distant from one another in State government. However, substance abuse spending in States is much lower than mental health spending, which generally implies that substance abuse agencies are smaller. The sources of funding for mental health and substance abuse are quite different from one another.

    - Federal funding other than Medicaid and Medicare provides 16% of the funds for substance abuse but only 4% for mental health[5]. These funds are primarily from the Federal Block Grant Programs for substance abuse and for mental health.

    - Medicaid, a joint State-Federal program, provides substantially greater support of mental health services than of substance abuse treatment services, in part due to the Federal stipulation that people who are disabled due to drug addiction or alcoholism are ineligible for Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) benefits and, therefore, Medicaid coverage linked to these programs. SSDI and SSI remain important sources of support for individuals (children, adolescents and adults) with a mental health disability.

    - Substance abuse treatment services fall under the optional services that States can elect to cover or not cover under Medicaid.

    - For the nation as a whole, total State and Federal public expenditures for mental health are 5.5 times the public expenditures for substance abuse, and State expenditures for mental health are 6.2 times those of State expenditures for

[5] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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substance abuse[6]. In comparing State spending for mental health and substance abuse, the majority goes to mental health: 86% of total State and local spending for mental health and substance abuse went for mental health in 1997.

- Respondents from States where services are provided by some entities that combine substance abuse and mental health services and others that provide specialty substance abuse treatment services only reported that combined or integrated services had the following characteristics:
    - The definition of co-occurring disorders is broadened so that a much larger proportion of substance abuse patients are diagnosed with a mental health disorder.
    - Mental health practitioners and substance abuse practitioners have different evidence-based best practices and little or no cross training. Combining services administratively does not necessarily address this issue.
    - Practitioners with a mental health background are more likely to diagnose substance abuse patients as having mental health disorders than substance abuse disorders, an observation similar to what has been amply demonstrated in the literature on primary care physicians' propensity to diagnose some mental health disorders but to miss substance abuse disorders.

- Centralizing budget and fiscal functions that were formerly within the State substance abuse agency has been a component of consolidation efforts in several States. Staff from these departments believe strongly that this centralization caused in a loss of programmatic expertise, focus and priority in the substance abuse budgetary function. The centralization resulted in a lack of ability to understand or model the policy implications of proposed changes in substance abuse budgets and finances. Substance abuse financing/reporting required under the Federal Block Grant was believed by these individuals to have been negatively affected when the functions were centralized upward.

- Clients with co-occurring mental health and substance abuse disorders benefit both from mental health and substance abuse treatment services. According to the Federal Drug and Alcohol Services Information System, only 16% of substance abuse treatment admissions in 2001 were for clients with a

[6] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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1117 EUCLID AVENUE
BERKELEY, CA 94708

co-occurring mental health disorder[7], which was not necessarily a serious mental illness. Although this is probably a significant underestimate, since many of the programs that are funded by the SAPT block grant and supply the data for this observation do not have mental health professionals qualified to make a diagnosis of a mental health disorder, the point remains that most people who are treated for substance abuse are not found to have a mental health disorder.

Turning to the epidemiologic perspective, 23.2% of the members of the targeted public mental health population, clients with severe mental illness (SMI), also have a substance use disorder[8]. Moreover, about 29% report use of an illicit drug in the past year. Among adults with substance dependence or abuse, 20.4% had SMI, according to the National Survey on Drug Use and Health. The great majority of SA clients do not meet the public sector criteria for SMI necessary for entitlement to State-provided mental health services.

TABLE II

PERSONS AGED 18 OR OLDER WITH SERIOUS MENTAL ILLNESS (SMI) AND SUBSTANCE USE DISORDER (SUD)
2002[9]
(Thousands)

		SUBSTANCE DEPENDENCE/ABUSE		
		YES	NO	TOTAL
SMI	YES	4,048	13,435	17,483
	NO	15,749	159,674	175,423
	TOTAL	19,797	173,109	192,906

Because the intersection of the target populations for the two conditions in the general population – those who report serious mental illness and substance dependence/abuse – is such a small proportion of the total of the two populations (12.2%), treating co-occurring disorders may be more of a programmatic and clinical issue than an organizational placement issue within

[7] SAMHSA, Office of Applied Studies, *The DASIS Report*, "Admissions with Co-occurring Disorders: 1995 and 2001" April 9, 2004
[8] Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[9] *ibid*

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1117 EUCLID AVENUE
BERKELEY, CA 94708

state government. Basing a system reform or restructuring on treatment of co-occurring disorders affects only about one fifth of the SA population, while ignoring other concomitant problems of many persons with substance abuse disorders.

Regardless, it must be recognized that substance use and abuse is an important issue in the treatment of those with SMI. Not only do a significant portion of the clients in the public mental health population with SMI have a substance use disorder (SUD), but substance use by these clients, even in those without SUD, can significantly undermine behavioral stability. Moreover, the prevalence of SUD in the SMI population is higher in urban areas, higher for adolescents than for adults and may be higher among public sector clients than in the population treated elsewhere. Therefore, collaboration with the State substance abuse agency is of critical importance for State mental health agencies, whereas the State substance abuse agency perceives the mental health agency as one of many State agencies with which collaboration is needed. This disequilibrium in perspectives is a potential source of tension between the two agencies. Several substance abuse agency Directors indicated that they felt more need to collaborate with criminal justice agencies than with mental health agencies.

The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency that its ability to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control on behalf of its clients. However, the evidence developed to date in this nine State study clearly indicates that this submersion or merger would or actually has significantly degraded the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to collaborating with the mental health agency.

Other Significant Policy Issues Raised by Respondents

- Political attitudes towards and sympathy or lack of support for substance abuse treatment have an importance beyond structure and leadership:
    - One strong Director in a "nested" (See definition, following) department mentioned that over the past five years there had been four individuals in positions superior to his in the Department: two

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1117 EUCLID AVENUE
BERKELEY, CA 94708

CADPAAC Response to Health and Human Services Agency Stakeholder Survey

California Performance Review Recommendations

The following comments constitute the response of the County Alcohol and Drug Program Administrators Association of California (CADPAAC) to the Stakeholder Survey. These comments address the specific recommendation of the California Performance Review that the administration of the state's substance abuse and mental health programs be consolidated.

Recommendations on Programs Administered by Government:

Question 1: Will the proposal improve access to services? Does it make it simpler for customers/clients?

Answer: CADPAAC believes that the proposal may improve access to services for those clients diagnosed with co-occurring mental health and substance abuse disorders. However, recent figures from the federal Substance Abuse and Mental Health Services Administration indicate that only 23% of adults with serious mental illness have a co-occurring substance use disorder, and only 12% of the combined population of individuals with either substance use disorders or serious mental illness have both diagnoses. While service access to this population may be improved, the consolidation proposal will substantially reduce or disrupt the availability of and access to services for the vast majority of clients with an alcohol or other drug abuse disorder. Currently, clients with alcohol and other drug (AOD) abuse issues are well served in counties with easily-identifiable and distinct programs providing AOD prevention and treatment. CAPDAAC fails to see how it would be "simpler" for these clients to navigate through a behavioral health or mental health system to find the appropriate services they need. The primary barrier to treatment access is not organizational, but the fact that both the AOD and Mental Health systems are severely under-funded relative to need.

Question 2: Will the proposal improve delivery of services?

Answer: CADPAAC believes that service delivery for most clients with AOD-specific needs will be severely curtailed under this proposal. Reimbursements, contracts, reporting issues, etc. are very different for AOD services than for mental health. Moreover, the fact that mental health services, most of which are mandated, are given funding priority over discretionary AOD programs, would mean that AOD services are more vulnerable to reduction or even elimination.

Question 3: Will the proposal improve outcomes?

Answer: As with service delivery, outcomes may improve for a minority of clients diagnosed with co-occurring disorders. However, for the majority of clients with AOD-specific needs, positive treatment outcomes may decline in a new department that focuses on behavioral health. In Santa Clara County, for example, actual data for the last complete year show that only 1-2% of clients in both the AOD and Mental Health systems combined are treated in both systems during the year. Just over 10% of the total number of clients in both systems were seen in both systems at some time during the year, but not concurrently. While various estimates show much higher figures, depending on the studies cited, when actual numbers from a major county are used, the overlap of clients between the two systems is very small.

Question 4: What will be the impact on the service provider network?

Answer: This question could be better answered by the providers themselves. CADPAAC believes the AOD service provider network will be negatively impacted by this proposal. Providers that contract with county AOD administration or with the State Department of Alcohol and Drug Programs (ADP) are subject to federal requirements, contracts and cost reporting systems, Drug/Medi-Cal contract monitoring, data collection and reporting, licensing and certification, oversight and evaluation activities for various criminal justice programs, all of which are much different for AOD programs than for mental health. Providers could face substantial disruption of and costly changes in their programs under the Commission's proposal.

Question 5: Will the proposal improve program efficiency?

Answer: CADPAAC believes that the proposal will ***reduce*** program efficiency. AOD programs that receive Federal funding are subject to specific Federal accountability standards and maintenance of effort (MOE) requirements distinct from mental health programs. Without a separate state department to administer these services, efficiency will be compromised.

Recommendations on the Organization/Structure of Government:

Question 1: Will the reorganization proposal improve service delivery and outcomes for clients?

Answer: As with Question #1 above, CADPAAC believes that for clients diagnosed with co-occurring AOD addiction and severe mental illness, the proposal may improve service delivery and outcomes. However, the proposal will ***reduce*** service delivery and outcomes for most AOD clients, for the reasons enumerated above.

Question 2: Will the proposal promote better coordination and integration of policy and programs for specific client groups?

Answer: As the Little Hoover Commission concluded, coordination of programs is best promoted on the local level by leadership development, replication of successful collaborations, and removal of barriers to cooperation, rather than by department merger at the State level. CADPAAC believes that the merger proposal would actually hinder the coordination of AOD services with other systems impacted by AOD issues, such as criminal justice, public health, child welfare and social services.

Question 3: Does the proposal provide better accountability for specific client groups?

Answer: CADPAAC believes that the proposal will not provide as good accountability for AOD clients as currently provided by a separate State department for alcohol and drug programs.

Question 4: What are the strongest reasons for implementing this recommendation? What are the greatest potential concerns?

Answer: The strongest argument in support of this proposal is that some counties have already consolidated AOD and mental health services within a behavioral health model. While such consolidations may have achieved a measure of administrative streamlining and cost savings at the local level, there is still great debate as to whether clients with AOD-specific needs are being well served by a behavioral health system. Moreover, there are no valid studies or data as to any real cost savings that would accrue as a result of the merger of the two departments at the state level.

CADPAAC's greatest concerns about the proposed consolidation are outlined in its letter of public comment to the California Performance Review Commission (attached).

The Stakeholder Survey also invites comments and suggestions as to how given recommendations could be modified to better advance their intended objectives. If the goal is to improve the efficiency of AOD programs, CADPAAC would recommend implementing the Little Hoover Commission's proposals as outlined in its 2003 report, ***For Our Health & Safety: Joining Forces to Defeat Addiction***. The LHC's five recommendations are:

1. The establishment of a State Council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of AOD abuse.
2. Working with counties, the State should set broad goals for treatment programs, and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm on their communities.

3. Implementation by the State of outcome-based quality control standards for treatment personnel, programs, and facilities, and encouragement of continuous quality improvement.
4. Facilitation by the State of the integration of AOD treatment with other social services to effectively reduce abuse and related public costs.
5. The State should immediately maximize available resources that can be applied to AOD treatment.

It is interesting to note that, in its recommendation to integrate AOD treatment with other social services, the Little Hoover Commission nowhere suggests that this goal would be achieved or furthered by the statewide consolidation of AOD and mental health services. Rather, integration is best achieved by the development of leadership in all fields, the replication of successful cooperative programs on the local level, and the creation of a process to identify and remove barriers to collaboration. CADPAAC would agree with these goals, and believes that the proposed AOD-Mental Health consolidation would jeopardize the collaboration of AOD services not only with mental health, but with criminal justice, public health, education, child welfare, social services, and other systems that are impacted by alcohol and drug abuse issues.

Analysis of CPR Recommendation to Consolidate Mental Health and Alcohol and Drug Programs

Importance of State Substance Abuse Services and Policy

- Untreated substance abuse imposes significant costs on many parts of the community and state government:
  - Excess physical health costs and overuse of costly emergency services
  - Endangers public safety, causes auto and workplace accidents
  - Endangers child welfare; increases domestic violence
  - Overcrowds state criminal justice facilities and courts
  - Creates public housing problems and encourages and complicates homelessness
  - Degrades educational productivity and requires vocational rehabilitation
  - Degrades workforce productivity and safety
  - Complicates mental health and medical treatment
  - Increases burden on overburdened state and local police, courts, correctional systems, social services

Importance of Freedom to Collaborate

- Many other State agencies have significant numbers of difficult clients with substance abuse problems.
- State substance abuse agencies must collaborate with other agencies to implement effective SA policy and services.
- Effective collaboration requires the SA agency to be visible, autonomous and to have "clout".

CPR Uses Prevalence of Co-Occurring Disorders to Justify Consolidation

- CPR report states that "of those persons diagnosed with serious mental illness, 41% have alcohol or other drug disorders".
- On the contrary, more recently released figures from SAMHSA show that in 2002 only 23% of the adults with serious mental illness (SMI) have any substance use disorder (SUD) at all.
- Only 12% of the combined adult population of individuals with either substance use disorders (SUD) or serious mental illness (SMI) were found to have both diagnoses (SUD and SMI).

Co-Occurring Disorders Are a Clinical Issue

- CPR Report says that the prevalence of co-occurring disorders requires consolidation.
- Effective treatment of co-occurring disorders is an important programmatic and clinical issue but only for specific patients; the prevalence of 12% co-occurring disorders in the combined target populations of ADP and DMH is insufficient to serve as a rationale for consolidation, as opposed to cooperation, of the two departments.
- SUD's and SMI also "co-occur" very frequently with physical illnesses, developmental delays, criminal justice issues and social/economic problems. If co-occurrence were to be the logical basis for departmental mergers, one would need to examine whether ADP or DMH should be merged with these other functions or departments.

Specialized Nature of Alcohol and Drug Treatment

- CPR Report states that there are "increasing similarities in the [drug/alcohol and mental health] treatment approaches ... not fully understood or appreciated by the two disciplines".
- As evidence for this convergence, CPR Report cites the "recovery approach" and certification of treatment providers and staff.
- The similarities are said to justify consolidation.

Recovery and Certification Do Not Imply Need for Consolidation

- Recovery is a clinical, programmatic and spiritual/philosophical goal for all chronic disease, not a sound fiscal or policy rationale for merging any particular state departments that serve individuals with chronic disorders.
- Treatment providers and staff in substance abuse treatment require certifications quite different from those in mental health treatment. Certification is a mechanism used in many fields to require minimum standards for treatment providers and staff, not to justify merger when standards are so different.

Relapse and Substance Abuse

- To justify consolidation, CPR also attributes SUD relapse primarily to "untreated psychiatric disorders", citing a 1997 SAMHSA report.
  - A more recent (1998) meta-analysis of 69 such studies concluded that the phenomenon of SUD relapse was "complex" and that "no single variable strongly predicts continued drug use."
- CPR also quotes SAMHSA as saying "the most common cause of psychiatric relapse today is use of alcohol, marijuana, and cocaine." This 1997 statement by SAMHSA actually refers only to seriously mentally ill individuals **with co-occurring disorders**, not to all individuals with mental disorders as CPR states.
- Implication: CPR Report overstates relationship between mental illness relapse and substance abuse; relapse is a complex clinical phenomenon that has many reasons other than co-occurrence; it does not imply a need for consolidation of the two disciplines at the organizational level.

CDP Report Cites Mental Health Sources that Favor Consolidation

- National Association of State Mental Health Program Directors (NASMHPD) cited, but not the National Association of State Alcohol/Drug Abuse Directors (NASADAD) or CAADPE (California Association of Alcohol and Drug Program Executives).
- Administrator of newly combined Department in Oregon cited by CPR as in favor of consolidation was originally from mental health department.

CPR Neglected Substance Abuse Sources and Experience of Comparable States

- CPR did no analysis of the larger, more diverse, states that are comparable in population to CA (e.g. Texas, New York, Florida or Ohio), where MH and SA have not been merged despite recent reorganizations ordered by the legislatures and/or the Governors.
- California County interviewees cited in report were 7 directors (out of 57 counties) all of whom had combined responsibilities, not county SA directors and not the majority of CA counties.
- No evidence cited even in these instances that SA staff agreed with the 7 mergers or that these counties' stakeholders were pleased with their effects on clients.

CPR Neglect of Substance Abuse Sources

- No citations at all from national academic policy experts in SA (Thomas McClellan, PhD, Constance Weisner, Ph.D. – both on IOM *Crossing the Quality Chasm* Committee) – did not even cite UCLA researchers, UCSF researchers or UCSD researchers known internationally in SA clinical and policy research.
- No states cited where ADP/MH mergers were rejected or avoided (eg. Florida, NY, Texas, Ohio, Michigan).

Substance Abuse Agencies Across the US Oppose Merger with Mental Health

- Substance abuse agencies are much smaller than mental health agencies but have much higher proportion of Federal block grant funding.
- Consolidation subsumes the smaller department within the larger one, threatening MOE requirements and reporting attached to SAPT block grant.
- In general, mental health departments prefer consolidation with substance abuse departments and substance abuse departments oppose consolidation.
- State substance abuse agencies typically believe that consolidation with mental health significantly degrades their ability to promote effective substance abuse services and policy. Those who have actual experience with consolidation have evidence of this problem.

Substance Abuse Agency Placement in Comparable Large States

- Texas
  - SA agency is co-equal to MH agency within the Community Mental Health and Substance Abuse Services Section.
- New York
  - SA agency at cabinet level with Director appointed by Governor
  - Last major re-organization in 1995-1996 replaced a "super-agency" with three separate units: SA, MH and MRDD.
- Florida
  - Director of SA agency is also Deputy Director for Treatment in Florida Office of Drug Control; has direct access to Governor.
  - Director of SA and Director of MH report that SA agency used to report to mental health agency; now that it is co-equal to MH, SA has been able to promote SA priorities in a way that he was never able to when subsumed under MH.
- Ohio
  - SA agency at cabinet level with Director appointed by Governor.

ADP and DMH Have Different Organizational Funding and Focus That Makes Consolidation Problematic

- Targeted DMH focuses on persons with SMI and has relatively low Federal block grant funding; ADP focuses on serving everyone with dependence or abuse problems, whether or not severe – all of whom are also clients of almost every other state department and ADP has high proportion of funding from Federal block grant; consolidation would endanger ADP compliance with Federal block grant requirements.
- DMH culture and organizational emphases not in synch with these differences. Consolidation of ADP with DMH is not likely to empower ADP to collaborate with other state departments as is necessary. Collaboration that saves CA money will be obstructed (eg Prop 36).

CPR Analysis: Purpose, Method and Requirements

- Charge from Governor: Based on evidence of performance deficits, Identify opportunities for savings, efficiencies and performance improvement across state government
- Method: Use evidence-based and balanced policy analysis and assessment to yield valid recommendations for major policy changes and organizational designs
- Requirements for such policy analysis: absolute accuracy and thoroughness in developing evidence; citing up-to-date evidence regardless of what that evidence shows; non-selective use and reporting of complete and unbiased analysis of that information; savings or cost estimates based on valid data that support savings projections; complete understanding of agencies' missions, funding and stakeholders' needs and requirements; analysis subjected to fair and thorough external review by recognized SA and MH subject matter experts; implications and recommendations supported by evidence, not author preference.

Policy Analysis Requirements vs. CPR Analysis of ADP/DMH Issues

- Accurate, thorough use of evidence? No
- Use of latest scientific evidence? No
- Non-selective, complete data? No
- Unbiased sources and data analysis? No
- Complete understanding of agencies' missions, funding and stakeholder needs and requirements? No
- Review of analysis and recommendations by qualified expert subject matter experts from SA and MH? No
- Recommendations supported by data? No

ACHSA Issues/Concerns Re: Potential Merger of ADPA with LACDMH

1) Potential difficulty with the integration of conflicting cultures.
[According to the 2004-2005 L.A. County Civil Grand Jury Report, "There has been much controversy within the mental health and substance abuse communities regarding the relationships between the two populations of clients. During interviews we were advised that substance abuse clients generally do not want to be 'stigmatized' by being associated with mental illness. On the other hand, mental health clients and their families see mental illness as a disease which encompasses much more than the substance abuse issues that are presented by the patients."]
2) Ability of DMH to absorb new program within the existing organizational structure at the macro level (Finance, Contracts, Management by District Chiefs).
3) Increased burden on DMH administration at the micro level (with 300 new ADPA contracts to process).
4) Would the merger (actually technically referred to as "nesting") result in a true "integration" between ADPA and DMH? While the two programs could be housed in the same department, would they have equal standing and be able to achieve integration?
5) How would mental health providers feel about the establishment of a new Behavioral Health Department, with co-equal Mental Health and Substance Abuse Divisions?
[According to CAADPE, if the Board of Supervisors ultimately approves the merger of ADPA into LACDMH, the drug and alcohol providers would fight hard for such an integrated new department, which is probably the only way they would live with the merger.]
6) Same concern of drug and alcohol clients and providers as mental health clients and providers have had when the prospect of DMH being subsumed by DHS was being proposed -- an inadequate voice and consideration among other priorities.
7) Concern that if ADPA is merged with DMH the drug and alcohol CBOs would receive less contracted funds (fear that the merger would lead to money being redirected to directly operated programs).
8) How would DMH administer traditional ADPA programs (e.g., drunk driver programs; Penal Code 1000 deferred entry of sentencing; funding of community coalitions that deal with alcohol/drug related issues such as billboards)?
9) With regard to ACHSA, there would be a larger group of potential member agencies. However, due to the small size of the majority of contracted ADPA providers, there would be a question as to affordability of ACHSA membership. Some existing ACHSA member agencies may also consider potential new ADPA member agencies as "diluting" the Association.
10) Since ADPA is the largest pot of money with the County Department of Public Health, the future of that department would be put in question (countywide issue).
11) Given the current financial situation at the county, state, and federal levels, it is questionable as to whether this would be the best time to implement this proposed merger or create a new behavioral healthcare department.

Key Findings from SAMHSA Study, Dated 8/17/04, on Analysis of Placement of Alcohol and Drug Abuse Services within Different State Administrative Structures

1) To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within an agency that does not fully share its priorities and mission.
2) Collaboration with State mental health agencies is a key function for State substance abuse agencies. However, treating co-occurring disorders is more of a programmatic and clinical issue than an organizational placement issue within state government.
3) The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency or State government that the ability of the mental health agency to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control. However, the evidence developed to date in this nine State study clearly indicates that this submersion would significantly degrade the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to its collaboration with the mental health agency.

Conclusion and Possible Recommendations

1) By simply merging, or more accurately nesting, ADPA into LACDMH there is a lack of clarity as to any real benefit that would accrue to the clients served by either entity. While it might save the County money, by eliminating potentially duplicative administration, this benefit would be more than offset by the significant added administrative burden placed on LACDMH, which is already dramatically overburdened, likely causing negative impacts on current community mental health agencies and their clients.
2) The potential benefits of increased integration could be obtained by the development of improved working relationships between ADPA and LACDMH outside of the merger.
3) It is recommended that ACHSA not take a formal position on this proposal, but rather meet with Phillip Chen, Supervisor Antonovich's Health Deputy, to share some of our issues and concerns. Key agencies within the Supervisors' district would be attempting to help educate Phillip rather than attack what is undoubtedly a well intended idea.
4) It is recommended that ACHSA also consider meetings with Dr. Southard and Deputy CEO Sheila Shima on this proposal.

Attachment II

Los Angeles County Mental Health Commission

MHSA Oversight and Accountability

550 South Vermont Avenue, 12th Floor
Los Angeles, California 90020
TEL: (213) 738-4772 ~ FAX (213) 738-2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://dmh.lacounty.info/mhc

August 21, 2009

TO: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Jerry Lubin, Chair
Mental Health Commission

RESPONSE: TRANSFER OF ALCOHOL AND DRUG PROGRAM ADMINISTRATION TO THE DEPARTMENT OF MENTAL HEALTH

BACKGROUND

On July 9, 2009, the Los Angeles County Mental Health Commission received the July 1, 2009 Progress Report on the above noted subject. Our July 23, 2009 meeting was used as a discussion forum to gather information from each Commissioner and the attending stakeholders. An agenda announcing the open discussion/meeting was posted for information to the general public. During that meeting, there was an opportunity to address and get information from CEO Representatives; Loreto Maldonado, Richard Martinez, and David Seidenfeld, as well as an attending liaison from Alcohol and Drug Programs, Tami Omoto-Frias. We also distributed the document to our Service Area Advisory Committee Chairs (8) and the Department of Mental Health (DMH) Office of Empowerment and Advocacy and the DMH Client Coalition. These groups represent the countywide, ethnic and cultural diversity of mental health clients and families.

OVRERVIEW OF COMMISSION MEETING ON JULY 23, 2009

Introduction, acknowledgement, and gratitude were expressed among the presenters and the Commissioners. The presenters stated the purpose of the presentation. On October 7, 2008, the Board approved a motion by Supervisor Antonovich instructing the Chief Executive Office to develop recommendations regarding the transfer of Alcohol and Drug Programs Administration (ADPA) from the Department of Public Health to the Department of Mental Health. The purpose of the meeting was to present the CEO's interim report to the Commissioners and solicit and obtain their input on the issue.

The study involved collecting background information from the key participants (stakeholders); Commission on Alcoholism, Narcotics and Dangerous Drugs Commission, and the Mental Health Commission. Each stakeholder's department formed a workgroup and produced an Issue Paper that identified their concerns and perceived advantages, disadvantages and other relevant information regarding the placement of ADPA.

The discussion proceeded with an apology from the presenters for omitting the DMH response from the Issue Paper that was submitted in the Interim Report. The Commissioners expressed concerns that the solicitation process timeline was narrow. From the time Commissioners received the interim report to review, make comments and prepare pertinent questions, the time allowed was too short. Because of the short deadline, they felt they were being asked to "rubber stamp" or approve the interim report. The presenters reiterated their intent was to provide information and solicit input from the Commission as to the feasibility placement of ADPA into DMH. The Commission was not required to approve the interim report, only to make comments.

COMMISSIONERS AND COMMUNITY LEADERS QUESTIONS AND COMMENTS

Commissioner Sosa

Question: What is the fiscal impact of the transfer?

Chair Lubin

Question: A component appears to be missing. Substance abuse involves looking at what medicines and physical health issues clients may need. Will health services and the Sheriff Department play a role in the transfer? It appears the interim report does not address the specifics of how service delivery will be improved. It appears to be just moving the boxes.

Service Area Advisory Committee 6 Chair Ms. Eddie Lamon

Question/Opinion: Request for stakeholder input was too fast. More time is needed to allow a thoughtful decision. This is the wrong time to do the transfer based on the fact there are no savings for the first year. Savings are expected to be realized next year. Ms. Lamon suggested that a review of how to provide services to clients be performed and included in interim report.

Commissioner Perrou

Question: Is ADPA looking for a place to go?

Commissioner Sofro

Comment: The budget is far too serious and fragile to decide on the integration of services for those diagnosed with co-occurring disorders and those clients who need mental health services. We need to wait until later when the state budget is not so severe.

Commissioner Askins

Comment: The proposed transfer is by no means any slam dunk. Some things will be sacrificed. Efficiency may suffer when dealing with the long term work that has already been done. Looking at the disorders is not a good way to look at the issues. We are dealing with people, not disorders. Alternatively, it can be an opportunity but it should be done very carefully. Integration could enhance treatment, but may not out weight the losses.

The Commissioners and the CEO Representatives agreed to allow additional time for the Commission to further discuss the interim report at the August 13, 2009 Executive Committee meeting of the MHC.

RESPONSE TO INTERIM REPORT

After extensive discussion at the Executive Committee meeting, the Mental Health Commission concluded that it concurs with the Executive Summary from DMH in Exhibit B of the interim report. Overall, the benefits of consolidation are not apparent. Moreover, the consequences of consolidation may diminish the priority given to substance abuse, and likely not yield appreciable costs savings or efficiencies of scale and will likely have a marginal negative impact on DMH costs. Also, what impact will the transfer have on clients? Clients should receive all services from the several departments involved.

CONCLUSION

The intent in integrating ADPA and DMH to increase access and treatment is not a new idea. However, systems integration, while facilitating service integration, does not require the organizational merging of departments or programs. For this reason, the Commission again, concurs with the DMH position on the integration of ADPA and DMH.

JL:TLGN:tlgn

ch/executivecommittee/adpaltrtoboard

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 16, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

FINAL REPORT ON PROGRESS AND IMPACT OF THE SEPARATION OF PUBLIC HEALTH AND REVIEW OF PROGRAMS WITH POTENTIAL FOR TRANSFER FROM THE DEPARTMENT OF PUBLIC HEALTH TO OTHER DEPARTMENTS (AGENDA OF SEPTEMBER 22, 2009 SUPPLEMENTAL RESOLUTION BUDGET)

On May 30, 2006, upon approving the creation of an independent Public Health Department, your Board instructed this Office to report on the separation's progress on a monthly basis for the first three months of operation and quarterly thereafter for the first year to ensure that the transition occurs orderly and without incident.

Further, your Board instructed this Office, in consultation with SEIU Local 660 (now 721), affected departments, County Commissions, medical and hospital representatives, and health care advocates, to: produce a review of the impact of the separation that includes, but is not limited to, the effectiveness of the Memorandum of Understanding (MOU) between the departments of personal health, public health, and mental health to foster greater teamwork and service integration; and identify if there are any current public health responsibilities which, in the opinion of this Office, your Board should consider for possible placement in a different department with an accompanying recommendation and rationale.

Additionally, on June 22, 2009, during your Board's Budget Deliberations you requested a report by this Office and the Director of Public Health on programs that have the potential to be transferred from the Department of Public Health (DPH) to other County departments.

This Office has provided several reports to your Board regarding the separation of DPH from the Department of Health Services (DHS), the most recent of which was submitted on June 29, 2009. This represents our final report addressing the remaining items from the May 30, 2006 and June 22, 2009 requests. We have developed this report in consultation with DPH and DHS.

In summary, as discussed further below, the major steps to establish the separate DPH have been completed, although work continues on remaining ministerial changes to the County Code and the joint MOU between DHS, DPH and the Department of Mental Health (DMH). In addition, our review of the current DPH responsibilities has not identified any programs which should be transferred to other County departments. This includes the review of the proposed transfer of Alcohol and Drug Program Administration to the DMH, which was provided to your Board in a separate report.

PROGRESS OF PUBLIC HEALTH SEPARATION

The new DPH became effective on July 7, 2006. Two reports were issued by this Office on the progress of the separation of DPH from DHS during its first year of operation: the first on October 11, 2006, after its first quarter of operation, which included the DHS-DPH MOU; and the second on February 14, 2007, after its second quarter of operation. Included in the reports was a schedule that outlined the status of a set of implementation tasks related to the separation of the two departments. At the time of the February 14, 2007 report (Attachment I), the following implementation tasks were still in progress:

- Establish independent pharmacy operation for DPH;
- Reassignment of impacted employees/change of work location if needed;
- Development/completion of Antelope Valley Rehabilitation Centers appendix to the DHS/DPH MOU;
- *Follow-up ordinance changes;*
- Completion of cost allocations, Health Insurance Portability and Accountability Act (HIPAA) compliance issues, and development of additional MOUs with other County departments;
- Various finance/budget issues;
- Final implementation of DPH; and
- *Development/completion of MOU between DHS, DPH, and DMH.*

At this time, all but two of the tasks have been completed. The two tasks that remain are follow-up ordinance changes and the development/completion of the MOU between DHS, DPH, and DMH.

Ministerial Ordinance Changes: Although all substantive ordinance changes required to establish the separate DPH were approved by your Board in May 2006, several technical changes in the County Code still need to be made. DPH is working with County Counsel to ensure that the County Code is updated with these ministerial changes. We will work with both departments to complete these changes by January 31, 2010.

DHS, DPH, and DMH MOUs: Several funding and operational issues have been at the center of discussions since 2007 which have affected the work being done by the departments on the MOU between DHS and DMH. As last reported in our February 14, 2007 memo, this Office was continuing to meet with both departments on proposals to address the funding shortfall identified by DHS for psychiatric services, which would need to be reflected in the financing provisions of the MOU. Since that time, DHS and DMH have reached a funding agreement which is reflected in their respective budgets for the DMH funding of inpatient psychiatric beds at County hospitals. This funding agreement will be incorporated into the MOU.

In addition, discussions continued between DHS and DMH regarding psychiatric outpatient services and urgent care services at LAC+USC, which would also be incorporated into the MOU.

Further, DMH and DPH continue to work on collaborative and integrated approaches to address the needs of individuals with co-occurring substance abuse and serious mental illness. Given the scope of program responsibilities to be addressed in one or more of the DHS, DPH and DMH MOUs, we will work with the departments and County Counsel to complete the MOUs by June 30, 2010.

IMPACT OF PUBLIC HEALTH SEPARATION

As required by the DHS/DPH MOU, executed on July 6, 2006, a joint workgroup, comprised of DHS and DPH representatives, has been established and meets on at least a quarterly basis to discuss items within the MOU or any other topic affecting the two departments. Attachment II is a list of the DHS and DPH members of the core workgroup. The last meeting of this workgroup was held on June 25, 2009, and the next regular meeting is scheduled for September 30, 2009.

Under the DHS/DPH MOU, this workgroup is responsible for determining, on behalf of their respective Directors, where program collaboration has been successfully implemented and can be replicated in other program areas, or where barriers to efficiencies or service improvements may exist and where workable solutions must be developed to eliminate or mitigate those barriers.

Further, the workgroup has on-going responsibility for determining other program areas which should be incorporated into the MOU to further enhance interdepartmental collaboration. In meeting these responsibilities, the workgroup should seek input from stakeholder groups or experts in their respective program areas, as appropriate.

As provided for in the MOU, additions and revisions can be made to the MOU provisions by mutual agreement of DHS and DPH in an expedited manner that enables the departments to keep current the delineated roles and responsibilities of the departments. As an example, the Antelope Valley Rehabilitation Centers (AVRCs) Appendix to the DHS/DPH MOU has been added to the MOU as a major program component to the interdependent working relationship between the two departments. Attachment III is a copy of the AVRCs Appendix, which was agreed to by the departments in January 2007. Additional revisions are being reviewed by the departments on a regular and continuing basis.

The DHS/DPH MOU workgroup meetings have proven effective in the development and sharing of efficiency initiatives in which the two departments may be able to engage. Under discussion is the potential shared use of invoice processing software that may improve the workflow of the departments' purchasing and materials management operations.

As noted above, work is continuing on a joint MOU between DHS, DPH, and DMH in order to foster greater teamwork and service integration. The DHS/DPH MOU workgroup and DMH representatives will be given the task of developing the joint MOU on a timeline which targets completion by June 30, 2010.

While the joint MOU has not yet been executed, the three Health and Mental Health Services (HMHS) Cluster departments meet on a regular basis to discuss departmentwide initiatives and issues affecting their departments. HMHS departments form partnerships and integrate services wherever possible, recognizing that they often have patients/clients in common.

The HMHS Cluster departments also discuss administrative efficiencies in order to achieve cost-savings to address, in part, funding shortfalls resulting from increasing costs, shrinking or stagnant revenue streams and State budget reductions. A recent example of interdepartmental teamwork among the HMHS Cluster departments, as well as the Sheriff's and Probation Departments, is the pharmaceutical cost savings initiative. As outlined in the May 20, 2009 report from this Office to your Board, DHS initiated innovative strategies to manage the rising cost of pharmaceuticals and their practices were extended to the noted departments. As a result of this effort, cost-effective pharmaceutical purchasing practices were shared between the departments and are expected to result in increased cost-savings as these practices are refined.

As to your Board's request regarding the impact of the separation of DHS and DPH, the June 29, 2009 report from this Office to your Board reiterated several reasons for establishing a separate public health department, among them the varying missions and priorities of the departments, as well as the new and existing public health issues which warrant a separate organizational focus and direct responsibility of preventing and controlling serious threats. Further, the establishment of the separate DHS and DPH allows for a better focus on the financing requirements of each department and their respective responsibilities and abilities for addressing their budgetary challenges. It is important to note that, while operational efficiencies are being pursued which could benefit both departments, the specific revenue raising strategies and programmatic changes are, in most instances, unique to each.

POTENTIAL PROGRAM TRANSFERS

In response to your Board's instruction to report on programs that have the potential to be transferred from DPH to DHS, this Office convened an interdepartmental workgroup, comprised of representatives from DPH and DHS. The interdepartmental workgroup conducted its assessment by differentiating between programs whose mission is solely focused on public health and programs with broad, cross-cutting competencies and missions.

Programs whose mission is solely focused on public health would not be recommended for potential transfer as they form DPH's core mission to protect health, prevent disease, and promote health and well-being. These programs are the core of DPH and to transfer them to another department would undermine the balanced portfolio of public health services that is currently in place. On the other hand, programs with broad, cross-cutting competencies and missions offered the potential for placement in other departments. The DPH programs discussed by the interdepartmental workgroup for possible placement in another County department included:

- Alcohol and Drug Program Administration;
- Antelope Valley Rehabilitation Centers;
- Children's Medical Services; and
- Office of Women's Health.

Alcohol and Drug Program Administration

Alcohol and Drug Program Administration (ADPA's) mission is to reduce community and individual problems related to alcohol and drug abuse through evidence-based programs and policy advocacy. The inherent public health nature of ADPA's services were noted, including the proximity and intertwined relationship to other DPH programs. Of particular note, is ADPA's relationship with the Tobacco Control and Prevention, as well as, the Health Assessment and Epidemiology Programs. ADPA was recently evaluated as part of a comprehensive analysis led by this Office as to the organizational placement of the program for possible transfer to the DMH. As noted above, a separate report has been submitted to your Board, which includes our recommendation that ADPA remain in DPH.

Antelope Valley Rehabilitation Centers

Antelope Valley Rehabilitation Centers (AVRC's) mission is to contribute to the restoration of the overall health and functioning of County residents who suffer from substance abuse and addiction. Prior to the public health separation, AVRCs were part of the DHS ValleyCare Network. When the recommendations were developed regarding programs which should remain in DHS or be part of the new DPH, this Office recommended that AVRCs be moved from DHS to DPH because of the public health nature of the substance abuse rehabilitation services provided by AVRC. Additionally, this program has an inherent linkage with ADPA. The subsequent review by the interdepartmental workgroup concurred with the placement of AVRCs in DPH.

Children's Medical Services

Children's Medical Services (CMS') mission is to provide preventive screening, diagnostic, treatment, rehabilitation, and follow-up services. The inherent public health nature of the services provided under the program, the proximity and intertwined relationship the program shares with other DPH programs was noted. The CMS program was considered for possible placement in DHS as an alternative due to the types of services provided in the program; however, based on their review, the interdepartmental workgroup recommended that CMS continue to reside within DPH. This recommendation was due to DHS' prime mission of direct patient care and service delivery, as opposed to CMS' spectrum of services which are broader, and includes screening, diagnostic, and treatment services via public and private hospitals or clinics, as well as community-based providers. Furthermore, as children and families are, at times, referred to DHS facilities for the provision of care, placement of CMS under DHS would raise conflict of interest concerns. Such concern would be raised as DHS, a possible provider, would not only be responsible for providing services to these clients, but also be responsible for referring these clients for care.

Office of Women's Health

Office of Women's Health mission is to improve the health status of women in the County by serving as the focal point for strategic planning, promoting comprehensive and effective approaches to improving women's health, and promoting the expansion of funding for research activities. Although the program was first established with a patient care aspect as one of its prime objectives, the program has evolved into a more administrative and strategic planning program that seeks to improve women's health via policy development and the expansion of funding opportunities for research activities that will lead to improved health outcomes for women.

Health Authority Law Enforcement Task Force

In addition to the aforementioned DPH programs, the interdepartmental workgroup briefly discussed the placement of the Health Authority Law Enforcement Task Force (HALT) program in DHS. As your Board may recall, the transfer of the HALT program to DHS from DPH was approved by your Board as part of the Final Changes recommendations on June 22, 2009.

It should be noted that at the time of the public health separation in 2006, the HALT program remained with DHS. However, subsequent to the establishment of DPH, the HALT program was approved by your Board for transfer from DHS to DPH as part of the 2007-08 Proposed Budget actions. At that time, the transfer of the HALT program to DPH was recommended, in part, to recognize the program's focus on securing and maintaining the public's overall health and well-being, and the agreement between the two departments at that time to the organizational placement of the program in DPH.

The return of the HALT program to DHS, as part of the 2009-10 Final Changes recommendations, was based, in part, on the alternate recognition of the healthcare component of the program, the program's policing and deterrence of illegal healthcare practices by unlicensed physicians and/or private County residents, and the current agreement between DHS and DPH that the program's placement under DHS was, after further review, appropriate.

The changing perspective on the placement of the HALT program is an example of the challenges faced by DHS, DPH and this Office in reviewing and recommending placement of programs that have cross-cutting competencies and missions. Ultimately, the primary goal is ensuring that the programs are able to provide the most effective services to the public, regardless of their organizational placement.

STAKEHOLDER INPUT AND PROGRAM PLACEMENT

A key component of our analysis as to program placement, involves stakeholder input. During our comprehensive assessment of the appropriate placement of the County's ADPA, either in DPH or in DMH, we obtained valuable stakeholder input from meeting with the County's Commission on Alcoholism, Narcotics and Dangerous Drugs Commission, and the Mental Health Commission. These various commission meetings were conducted on July 8, 2009, July 15, 2009, and July 23, 2009, respectively. Furthermore, written comments were received from the Public Health and Mental Health Commissions. It was the unanimous opinion of these two Commissions, as well as their constituents, that ADPA should remain within DPH and not be merged with DMH.

It should be noted that the HMHS Cluster departments meet regularly with their respective Commissions, and they advise this Office that they are not aware of any Commission recommendations for the transfer of DPH programs to another County department.

While there are no current DPH programs which, in the opinion of this Office, should be recommended for possible placement in a different department, we will continue to look for instances where a rationale exists as the DHS/DPH MOU workgroup continues its review of DHS and DPH programs and the HMHS Cluster departments continue its work on a joint MOU. Should this Office or the HMHS Cluster departments identify a rationale for recommending that DPH programs be placed in a different department, we will so advise your Board and, following standard operating employee relations procedures, we will work with SEIU Local 721 and/or other affected employee union/s in conducting our analysis of the potential transfers.

SUMMARY

The overall separation of DPH from DHS has proceeded in an effective and efficient manner. Budgetary and/or operational adjustments between the two departments have been necessary as part of the transition, but they have for the most part been minor in nature. Most importantly, the departments have established a collaborative process to address these types of adjustments, which was not clearly delineated prior to the separation.

In addition to DPH and DHS, DMH is a member of the group of HMHS Cluster departments, and their joint efforts have fostered greater teamwork. As a result of the efforts by the HMHS Departments, service integration among their programs and cost-effective practices are being assessed and shared. Opportunities for economies of scale are encouraged among the HMHS Departments, and if appropriate, with other County Departments.

There are no current DPH programs which were identified for possible placement in a different department. However, an evaluation process is in place and if findings warrant the transfer of programs, recommendations will be brought to your Board for consideration.

If you have any questions please contact me, or your staff may contact Richard F. Martinez at (213) 974-1758.

WTF:SRH:SAS
MLM:RFM:yb

Attachments

c: Executive Officer, Board of Supervisors
Acting County Counsel
Director, Department of Mental Health
Director, Department of Public Health
Interim Director, Department of Health Services

091609_HMHS_MBS_DPH Separation

Attachment I

County of Los Angeles
CHIEF ADMINISTRATIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION • LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://cao.lacounty.gov

DAVID E. JANSSEN
Chief Administrative Officer

February 14, 2007

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

REPORT ON THE PROGRESS OF THE SEPARATION OF PUBLIC HEALTH FROM THE DEPARTMENT OF HEALTH SERVICES

On May 30, 2006, as part of your approval of a separate Department of Public Health (DPH), your Board instructed my office to report on a monthly basis for the first three months of operation, and quarterly thereafter, for the first year to ensure that the transition occurs orderly and without incident. This report provides a status of operations through the first six months of implementation, as summarized in Attachment I. Our last status report was submitted to your Board on October 11, 2006.

Your Board also instructed my office to report back within six months with a review of the impact of the separation and identification of any current Public Health responsibilities which should be placed in a different department. While we anticipated providing that report to your Board early in December 2006, we find that we require additional time to complete that review and consult with stakeholder groups. Our target date for completion and report to your Board is May 2007.

With respect to the Memorandum of Understanding (MOU) between the Department of Health Services (DHS) and the Department of Mental Health (DMH), we are continuing to meet with both Departments on proposals to address the funding shortfall identified by DHS for psychiatric services, which will be reflected in the financing provisions of the MOU. We will report further on these efforts in May 2007.

Our next quarterly report on DPH implementation will be provided to your Board in May 2007 and will include the status of implementation efforts through the third quarter of DPH operations.

If you have questions or need additional information, please contact me, or your staff may contact Darolyn Jensen of my staff at (213) 974-1124.

DEJ:SRH:DL
DJ:NH:RFM:bjs

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Auditor-Controller
Director of Health Services
Director of Mental Health
Director of Personnel
Director of Public Health

DEPARTMENT OF PUBLIC HEALTH
STATUS OF IMPLEMENTATION TASKS

#	TASK	START	END	UPDATE
1.	***Establish independent pharmacy operation for Department of Public Health (DPH)***	10/15/05	7/1/07	As of 12/22/06, DPH has filled 4 of 5 new budgeted pharmacy staff positions; a Pharmacy Services Chief II, a Pharmacist, a Pharmacy Technician, and a Pharmacy Helper. Efforts continue to fill the remaining position, Procurement Assistant I, with a targeted completion date of 3/1/07. DPH will have separate pharmacy operations, but will remain under DHS pharmacy licensure; however, DPH will have a separate clinic dispensary licensing. The separated pharmacy operations of DHS and DPH will jointly remain in the current pharmacy operations space at LAC+USC Medical Center. Separation of the pharmacy operations and DPH obtaining a separate clinic dispensary license are targeted for no later than 7/1/07. In the interim, DPH will continue to have pharmaceutical services provided by Department of Health Services (DHS) staff at LAC+USC Medical Center, as was in place prior to the establishment of the separate Department. DHS will continue to bill DPH for pharmaceutical purchases.
2.	***Meetings with employee representatives/unions***	2/16/06	Completed on 7/31/06	DPH and DHS have met regularly with union representatives to discuss the impact of the separation on DHS and DPH employees. On 6/15/06, DPH and DHS provided union representatives with information on the process that would be used to select DHS employees to be reassigned to DPH and with drafts of notification letters which would be sent to DHS employees in affected administrative support areas. Additional meetings to discuss issues related to the separation will be scheduled as needed, but are not currently on the calendar.

#	TASK	START	END	UPDATE
3.	***Notice to employees regarding action/impact and informational meetings***	6/7/06	Completed on 7/6/06	On 6/16/06, initial notice was sent via e-mail to all employees and posted in all work areas of the Board's action to establish the new DPH. On 6/21/06, letters were sent to employees in administrative support areas affected by the establishment of the new DPH, requesting them to indicate their preference for remaining in DHS or transferring to DPH. Responses were requested by 7/6/06. On 6/26/06 and 6/28/06, DPH and DHS staff conducted Employee Forums (question & answer sessions) at DHS and DPH worksites for employees who might be affected by the administrative support transfers. In addition, DPH conducted Employee Forums for DPH staff on 7/26/06, 7/27/06, 7/28/06 and 8/8/06, with the objectives of allowing staff to meet the Public Health director and key managers; hear about the DPH vision, mission and strategic direction; learn about the new department and the transition process; and to respond to employee questions.
4.	***Reassignment of impacted employees/change of work location if needed***	7/17/06	7/1/07	All affected employees were formally advised by letter, dated 7/17/06, of whether they were being reassigned to DPH or remaining in DHS, and reassignments were effective 7/30/06. Proposed changes in physical location for affected employees are being coordinated between DPH staff and DHS-Facilities Management staff, and will be implemented on a phased-in basis. Some staff, for example, DPH Finance staff, will remain located at their present location in Commerce and no change is anticipated.

#	TASK	START	END	UPDATE
5.	***Development/completion of Antelope Valley Rehabilitation Centers (AVRCs) appendix to the DHS/DPH MOU***	2/28/06	3/31/07	DPH and DHS (Health Services Administration and ValleyCare Administration) staff continue to meet to discuss program and administrative issues to be addressed in the AVRC appendix to the DHS/DPH MOU. Draft appendix has been completed and is pending final review and approval. Target for completion of the appendix is 3/31/07. Discussions on DHS/DPH administrative support issues have covered: 1) Management support provided by Olive View Medical Center (OVMC) and High Desert Health System (HDHS), including 24/7 senior management support, transferred to Alcohol and Drug Programs Administration; financial administration; telephone systems; information systems equipment, software and support; pharmacy systems; and plant maintenance. Transfer of these operations is targeted for 3/31/07. In the interim, DHS is continuing to provide support. 2) Human Resources (HR) support, including additional positions added to DPH 2006-07 Budget during Supplemental Changes. Recruitment efforts are under way to fill the position; in the interim, DHS is continuing to provide HR support. 3) Ancillary support, including laboratory, radiology and urgent care. Because OVMC/HDHS staff did not previously track AVRC-specific use of these services, baseline data is not available to develop adjustments to the respective budgets. Therefore, DHS and DPH will monitor use for 12 months and budgetary adjustments will be developed for the 2007-08 Final Budget for DPH and DHS. Since these services are currently included in the ValleyCare Network 2006-07 Budget, DHS will continue to provide these services to AVRCs. 4) Other support services, including supplies and purchasing, custodial services and safety police are currently included in the ValleyCare Network 2006-07 Budget; DHS will continue to provide these services to AVRCs.
6.	***Follow-up ordinance changes***	6/7/06	5/31/07	DPH and County Counsel continue to work on additional "clean-up" County ordinance changes, as necessary, to Titles 2, 3, 10, and 11 of the County Code to bring them current with DPH operations, most unrelated to the separation from DHS. The first set of proposed changes, specifically to ordinances regarding DPH and DHS membership on various commissions have been completed and were approved by the Board on 10/3/06. These ordinance changes were adopted on 10/24/06. Completion of the remaining changes is expected to occur by May 2007 and will be submitted for Board consideration by April 2007.

#	TASK	START	END	UPDATE
7.	***Completion of issues such as methodology of cost allocations, HIPAA compliance issues, and development of additional MOUs with other County departments***	6/7/06	7/1/07	DPH and DHS staff are continuing to discuss allocations of costs related to services provided by one department to the other, including program services, such as tuberculosis services, laboratory services and substance abuse services, and administrative services, such as information systems, library services, facilities management and materials management. Further, discussions continue regarding other shared costs, including space utilization, utilities and warehouse usage, among others. DPH is continuing to review administrative support services which were previously provided via DHS, which DPH may now need to acquire directly from other County Departments. As needed, separate MOUs will be developed with the other County Departments. Per the implementation plan and the DHS/DPH MOU, DHS, DPH, CAO and Chief Information Office (CIO) staff are continuing discussions to appropriately identify costs for applications, shared infrastructure, and services that may be billed to the appropriate department. Budgetary adjustments, as needed, will be made during the 2007-08 budget process. Regarding compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements, the extent to which DPH and its operations should be designated as a covered health care component under HIPAA has been examined in consultation with County Counsel. It appears advisable to include the entire DPH in the health care component in order to continue the sharing of information between DPH and other entities with which such information was shared prior to the separation. Therefore, DPH is currently drafting a letter for consideration by the Board to approve DPH as a covered department. In the interim, DPH is continuing to operate under the requirements of the DHS HIPAA compliance plan. DPH, in consultation with County Counsel, has drafted the MOUs that will be required if DPH is designated as a covered component. The MOUs may be executed quickly, should the Board approve DPH as a covered department. MOUs would be needed with CAO, County Counsel, Auditor-Controller, Treasurer and Tax Collector, and the Internal Services Department. DPH and DHS are continuing to work with County Counsel on reviewing other potential issues related to sharing of information now that DPH is a separate department. Currently, there appear to be no changes to DPH and DHS information sharing as a result of the separation.

#	TASK	START	END	UPDATE
8.	***Finance/Budget Issues:*** ***Adjust budget to formalize creation of separate roll-up budgets for DHS and DPH budgets*** ***Consideration of potential surpluses/deficits to the DHS and DPH budgets***	6/7/06	7/1/07	As part of the Supplemental Changes phase of the 2006-07 budget process, the Board approved, on 9/26/06, the technical adjustments needed to create the separate "roll-up" budgets for DPH and DHS. Adjustments included the reallocation of DHS Health Services Administration overhead charges from DPH to the other DHS budget units. Additional adjustments are being developed consistent with the cost allocation methodologies related to program and administrative services provided by one department to the other and for the allocation of shared costs not identified in time to be included in the Supplemental Changes. Any additional adjustments will be included in the 2007-08 budget process. The 2006-07 Supplemental Changes included the use of $1.0 million in the 2005-06 year-end surplus generated by Public Health, which was put into the DHS designation during the 2005-06 year-end closing. The $1.0 million was one-time funding to help offset federal funding reductions in the Office of AIDS Programs and Policy (OAPP) budget. CAO staff are reviewing issues related to projected surpluses and deficits in DHS and DPH budgets and the potential allocation of County funding related to the 2007-08 Proposed Budget.
9.	***Final implementation of DPH***	7/6/06	7/1/07	The MOU between DHS and DPH was fully executed by 7/6/06. All actions related to the final implementation of DPH (i.e. physical staff reassignments, completion of follow-up ordinance changes) are expected to be completed by 7/1/07. As instructed by the Board, CAO staff are conducting a review of the impact of the separation and identifying any current Public Health responsibilities which should be placed in a different County department. Report to the Board is expected by 5/31/07.

#	TASK	START	END	UPDATE
10.	***Development/completion of MOU between DHS, DPH, and DMH***	3/31/06	7/1/07	A meeting with DMH, DHS, and CAO was held on 1-4-07 to discuss psychiatric services being provided to DMH and an appropriate reimbursement model. Discussions included funding limitations facing both DHS and DMH and their respective deficit management plans. CAO staff is developing the draft MOU between DMH and DHS regarding psychiatric services, including psychiatric emergency services, and the roles and responsibilities of each Department in providing those services. Completion of the draft MOU is expected by 7/1/07. CAO and DPH staff is reviewing services provided by DPH related to psychiatric services to determine whether they should be addressed in this MOU, or in stand-alone agreements.

LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES AND
DEPARTMENT OF PUBLIC HEALTH
MEMORANDUM OF UNDERSTANDING
WORKGROUP

Department of Health Services

Cheri Todoroff, Deputy, Planning and Program Oversight
Erain Muñoz, Associate Chief Financial Officer
Mela Guerrero, Controller

Department of Public Health

Jonathan Freedman, Chief Deputy Director
Miles Yokota, Administrative Deputy
Wendy Schiffer, Director, Office of Planning
Debbie Davenport, Director, Community Health Services
Robert Kim-Farley, MD, MPH, Director, Communicable Disease Control and Prevention
Carrie Brumfeld, Special Assistant
Bob Gibson, Special Assistant

Appendix A.16 **Antelope Valley Rehabilitation Centers (AVRC)** (New Appendix 1/22/07)

The Antelope Valley Rehabilitation Centers (AVRCs) consist of two large substance abuse residential treatment facilities, located in Acton and Warm Springs, and a smaller outpatient substance abuse treatment program, High Desert Recovery Center (HDRC) located on the campus of High Desert Health Clinic. The mission of the AVRCs is to provide quality, comprehensive and effective addiction treatment services for adult men and women. The AVRC's provide a model of care that is designed the meet the individuals treatment needs: which may include restoration of physical health, mental health, assessment and referral for legal issues, reconnection to family and society, unemployment, and continued education, all of which are often impacted as a result of the disease of addiction.

The AVRCs are comprised of three programs:

- **Acton Rehabilitation Center**, located at 30500 Arrastre Canyon Road, Acton, California. Acton Rehabilitation Center is a substance abuse residential treatment facility that has 309 beds licensed and is certified by the State of California to accommodate female (75) and male (234) residents.

- **Warm Springs Rehabilitation Center**, located at 38200 North Lake Hughes Road, Castaic, California. Warm Springs Rehabilitation Center is an all male facility that has 199 beds licensed and certified by the State of California.

- **High Desert Recovery Services**, located at the High Desert Health System Campus, 44900 North 60th Street West, Lancaster, California. High Desert Recovery Services (HDRS) is the AVRCs' Outpatient Program that offers an effective, low-cost alternative to hospitalization and residential care by expanding AVRCs ability to serve the needs of the Antelope Valley community and its surrounding areas. This is accomplished by providing quality outpatient alcohol or other drug treatment services including counseling, education, specialized services, and referral.

DPH will be responsible for all management and operations of the AVRCs with the exception of those services listed below that will be provided by DHS.

DHS, under the management of High Desert Health System (HDHS), will maintain on-site infirmaries that provide limited primary care and nursing services at the two AVRC residential treatment facilities: Acton Rehabilitation Center and Warm Springs Rehabilitation Center. HDHS will continue to provide space on the HDHS campus for High Desert Recovery Services (HDRS).

DPH and DHS agree to work to ensure a smooth transition for patients and staff at the AVRCs and to maintain frequent and consistent communication throughout the transition

period and ongoing to ensure the needs and interests of each department are appropriately articulated and represented.

Role of DPH

DPH will be responsible for all management and operations of the AVRCs with the exception of the on-site infirmary services listed below that will be provided by DHS. DPH will be the landlord for the two AVRC residential treatment facilities and will provide the following support to the DHS on-site infirmaries:

A. Building Maintenance - All building maintenance, including both the building interior and exterior, will be provided by the AVRC Building Crafts department. This will include, but not be limited to plumbing, electrical, roofs, and all building systems (HVAC, water, sewage).

B. Building Improvements - DPH will be responsible for the cost of any building improvements required to bring the infirmaries into compliance with Title 22 requirements, Americans With Disabilities Act (ADA) requirements, or other regulatory requirements.

C. Solid Waste - DPH will be responsible for the disposal of solid waste. The HDHS housekeeping contractor will deposit all solid waste in collection areas designated by DPH.

D. Utilities - DPH will provide all required utilities for the infirmaries at no charge, including electric, gas, sewage, telephone, and water.

E. Satellite telephone - DPH will be responsible for the satellite telephone purchase order at Warm Springs.

Role of DHS

DHS will maintain on-site infirmaries at Acton Rehabilitation Center and Warm Springs Rehabilitation Center. DHS will provide "Basic Services" and "Additional Services". Services that are identified as "Basic Services" will be provided for a fixed monthly fee, based on the estimated cost of operating the infirmaries, including appropriate overhead charges. Services that are identified as "Additional Services" will be provided by HDHS or by an HDHS contractor and will be billed as additional charges each month.

<u>Basic Services</u>

A. Hours of Operation - Both infirmaries will be open seven days per week, 365 days per year. During operating hours (7:00 a.m. – 10:p.m. M-F; 7:45 a.m. - 8:15p.m. on Saturday and Sunday), each Clinic will be staffed with a minimum of one Licensed Vocational Nurse (LVN) or one Registered Nurse (RN).

B. Staffing - Staffing for the clinics is based on the budget as reflected in the current item controls for Acton and Warm Springs Clinics, plus three additional items which have been temporarily shifted from other HDHS clinical areas in order to maintain minimum required staffing. The additional items are indicated below with an asterisk and will be requested in the FY 07-08 budget process.

Acton Rehabilitation Center:

- 1.0 - Supervising Clinic Nurse I (5329A)
- 2.0 - Clinic Nurse II (5328A)
- 1.0 - Clinic LVN II (5094A)
- .5 - Clinic LVN I (5090A)
- 1.0 - Clinic LVN I (5090A)*
- 1.0 - Clinic Nursing Attendant II (5088A)
- 1.0 - Int. Typist Clerk (2214A)
- 1.0 - Medical Steno (2180A)

Warm Springs Rehabilitation Center:

- 1.0 - Supervising Clinic Nurse I (5329A)
- 2.0 - Clinic Nurse II (5328A)
- 1.0 - Clinic LVN II (5094A)
- 1.0 - Clinic LVN II (5094A)*
- 1.0 - Int. Typist Clerk (2214A)*

C. Provider Staffing - HDHS will provide one full-time primary care physician (PCP) to staff the two infirmaries. This physician will routinely be assigned to the Acton Rehabilitation Center Infirmary on Mondays, Tuesdays, and Thursdays and to the Warm Springs Rehabilitation Center Infirmary on Wednesdays and Fridays. HDHS will arrange back-up coverage (physician or nurse practitioner) when the assigned physician has scheduled or unscheduled absences, when possible. Provider staffing will not be provided on County holidays or on weekends.

D. Admission Screening - Licensed nursing staff assigned to the infirmaries will provide pre-admission screening for prospective AVRC clients Monday through Friday. The purpose of this screening is to determine if prospective residents are medically appropriate for the AVRC program and environment, to assess each client's current medications, and to educate clients in regards to medication management while they are AVRC residents.

E. New Admission Processing - Licensed nursing staff will process new admissions as they arrive, and conduct nursing interviews and assessments to document medical and psychiatric history, screen for communicable diseases, record vital signs and height and weight measurement, test for Tuberculosis (PPD or referral for CXR), and initiation of a new patient chart.

F. Admission Physicals - The physician or back-up provider assigned to the AVRC infirmaries will complete physical examinations for all new admissions.

G. Sick Call - Licensed nursing staff will evaluate all patients presenting to the AVRC infirmaries with episodic or chronic medical problems. Based on the nursing evaluation, the patient may be 1) given advice and/or treatment by the nurse, 2) scheduled to be seen by the AVRCs infirmary provider, or 3) referred to the HDHS Urgent Care clinic or South Valley Health Center (SVHC) Urgent Care Clinic for non-emergency medical problems that require immediate attention. Treatment provided by the infirmary nursing staff will be based on standing orders or written or verbal orders from the AVRC infirmary provider. If a registered nurse is not on-site, a registered nurse will be available on-call during clinic hours for consultation.

H. Provider Review of Diagnostic Test Results - The AVRC infirmary provider will review all laboratory, radiology, and other diagnostic test results and take the necessary actions.

I. Provider Chart Review - Based on specialty consultation results, information received from providers treating clients outside the AVRC infirmaries, diagnostic test results, and other needs identified by nursing staff, the AVRC infirmary provider will review charts and initiate or change orders, as appropriate.

J. Medication Administration - The AVRC infirmaries will maintain a limited stock of medications for administration to clients with physician orders.

K. Medication Management - Licensed nursing staff will manage patient medications by 1) coordinating refill requests with the prescribing provider when a patient's medication requires refills; 2) requesting new and refilled medications through the HDHS pharmacy; 3) determining, based on established infirmary guidelines, which prescribed medications are to be distributed to the patient and which prescribed medications are to be held in the clinic; 4) checking medications to ensure that they were filled correctly; and 5) distributing medication prescriptions to clients with appropriate instructions.

L. Medication Observation - Licensed nursing staff at each infirmary will provide direct observed therapy (DOT) for clients receiving tuberculosis medications. Licensed nursing staff will also provide medication observation for all psychiatric medications, and for diabetic patients who self-administer insulin.

M. Patient Education - Licensed nursing staff will provide basic patient education regarding preventive care, self-care and disease processes, as appropriate.

N. Initial Management of Acute Psychiatric Problems and Psychiatric Emergencies - When needed, licensed nursing staff will assess patients with acute psychiatric problems and psychiatric emergencies and determine an appropriate plan. Alternative actions may include transport of the patient to an emergency room, referral to a Licensed Psychiatric Social Worker, or requesting assistance from the Psychiatric Emergency Team (PET Team).

O. Coordination of Mental Health Treatment - Infirmary staff will coordinate mental health treatment, including scheduling mental health appointments, interfacing with mental health providers, resolving psychiatric medication issues, and documenting patient failure to take psychiatric medications. Note: Refills for psychiatric medications must be written by a qualified psychiatrist and will not be rewritten or refilled by the AVRC Infirmary provider. Psychiatric medications prescribed by providers outside the HDHS system will not be filled by the HDHS Pharmacy.

P. Patient Health Records - Infirmary staff, under the direction of the HDHS Director of Health Information Management, will maintain active and inactive patient health records. The HDHS Director of Health Information Management is the custodian of records.

Q. Laboratory Services - The only on-site laboratory services provided at the AVRC infirmaries are point-of-care-test (POCT) for Blood Glucose for diabetic patients, and phlebotomy for other laboratory tests ordered by an AVRC infirmary provider. All laboratory specimens collected at the AVRC infirmaries are referred to the HDHS laboratory for processing or referral to a reference laboratory. POCT for Blood Glucose, Phlebotomy/specimen collection and performance of laboratory tests by the HDHS laboratory or an HDHS contracted reference laboratory are included in the basic services charge.

R. Transportation Coordination - Infirmary staff will notify AVRC staff when patients require transportation for medical services. AVRC staff will be responsible for providing or arranging for transportation to medical services.

S. Employee Health: Licensed nursing staff at the AVRC infirmaries will provide on-site employee health functions for DHS and DPH AVRC staff including annual employee physicals, and first aid for employee injuries. The HDHS Employee Health Department will provide new employee physicals for DHS and DPH AVRC staff.

T. Referral of AVRC Patients to DPH Clinics - The AVRC infirmaries will continue to refer patients to the DPH categorical clinics at Antelope Valley Health Center (TB and STD), and for chest x-rays at that clinic in association with TB clinic referrals, as appropriate. HDHS will have no financial responsibility for services provided to AVRC clients at DPH health centers and clinics.

U. Ancillary Services - All ancillary services (laboratory tests, radiology tests, electrodiagnostic tests, respiratory therapy tests/treatments, physical therapy, occupational therapy, and speech therapy) which are ordered by the AVRC infirmary provider will be referred to HDHS or a provider under contract with HDHS. The cost of these services is covered by the basic services charge based on prior year experience.

V. Housekeeping Services - The basic services charge includes the provision of daily housekeeping services for each AVRC infirmary by the DHS HDHS housekeeping contractor.

W. Furniture and Equipment - All furniture and equipment currently in the infirmary buildings will continue to be made available for use by HDHS, and will be removed by DPH upon request. HDHS will be responsible for the replacement and maintenance of all furniture and equipment required for the infirmaries.

X. Medical Waste - Any medical waste generated by the AVRC infirmaries will be disposed of by the HDHS medical waste contractor.

Basic Services Charge

The Monthly Basic Services Charge for operation of the AVRC infirmaries was developed based on Medicare Cost Reporting methodology, using the actual FY 2004-05 cost, adjusted by the cost-of-living increase for FY 2005-06 and the new housekeeping contract fees. The Monthly Basic Services Charge for each infirmary is:

Acton Rehabilitation Center Infirmary: $74,103

Warm Springs Rehabilitation Center Infirmary: $56,752

Note: The annual basic services charge for each AVRC infirmary will be adjusted in January of each year by the latest CPI percentage for the L.A.-Riverside-Orange County area and any additional structural changes required tomaintain Title 22 compliance, including any additional required staffing or contracted services.

Additional Services

Prescription Medications: Are not included in the basic services charge. All prescriptions for AVRC clients that are filled by the HDHS Pharmacy will be billed to DPH as an additional service. The charge for these medications will be the cost of the medication plus the Medi-Cal dispensing fee in effect at the time of service, per prescription. Currently the dispensing fee is $7.25 per prescription. The cost plus dispensing fees for FY 2004-05 was $220,210, and for FY 2005-06 it was $178,173.

Referral of AVRC Clients to HDHS Facilities

Financial Responsibility: AVRC patients may be referred to HDHS or its associated health centers for urgent care or specialty services. HDHS agrees to financially screen all such patients and to bill any available third-party coverage for services provided. In addition, HDHS agrees to screen AVRC clients referred to HDHS to determine eligibility for state or County assistance programs.

High Desert Recovery Services

HDHS will continue to provide 978 square feet of space on the HDHS campus for use by the AVRC High Desert Recovery Services outpatient substance abuse treatment program. DPH agrees to pay HDHS a flat fee of $6,078 per month to cover the cost of maintenance and repair, utilities, and housekeeping services for the space provided to HDRS.

Telephone Services: DPH agrees to pay the actual cost for telephone services, including line charges and local and long-distance usage, for all telephone/data lines used by HDRS, and for all telephone contractor service charges associated with the HDRS space.

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

December 4, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

SUPPLEMENTAL INFORMATION RELATED TO THE FINAL REPORT ON PROGRESS AND IMPACT OF THE PUBLIC HEALTH SEPARATION AND REVIEW OF PROGRAMS WITH POTENTIAL FOR TRANSFER (AGENDA OF DECEMBER 15, 2009)

On October 6, 2009, this Office was scheduled to present our memorandum dated September 16, 2009, and entitled, *Final Report on the Progress and Impact of the Separation of Public Health and Review of Programs with Potential for Transfer from the Department of Public Health to Other Departments.* That presentation was continued to the November 10, 2009, meeting of your Board and, subsequently, to your December 15, 2009 meeting.

BACKGROUND

As reported previously to your Board in our September 2005 Progress Report, this Office established a planning group, consisting of staff from the Department of Health Services (DHS), including Public Health, the Department of Human Resources (DHR), and this Office, in order to develop the comprehensive report and recommendations to your Board on establishing a separate Public Health Department.

At that time, the planning group discussed, in broad terms, the programs to be included in the separate Public Health Department, with the basic agreement that programs should be aligned as they were then, unless there were strong reasons to move them.

As directed by your Board on May 30, 2006, when approving the new Department of Public Health (DPH), this Office led a review of the programs in DPH "that identifies current Public Health responsibilities that are not aligned with its core mission and which recommends the most appropriate organizational setting for each of these programs." The report was included in our September 16, 2009 memo.

Further, this Office led a review that included programs in DHS to determine whether there were, similarly, DHS responsibilities that are not aligned with its core mission and could be recommended for transfer. Staff from the DHS, DPH and the Department of Mental Health (DMH) participated in this review.

This memo provides information which supplements, and in some instances incorporates, the response we provided in our September 16, 2009 memo and seeks to address subsequent questions and requests for information from your offices. Specifically, the review reported in this memo included the County's Emergency Medical Services (EMS) agency and Public Health Center clinic services (i.e. Tuberculosis [TB], sexually transmitted disease [STD], and immunization services).

DETERMINING CRITERIA FOR PROGRAM PLACEMENT

One of the most important criteria or factors in determining the organizational placement of a County program is assessing how the service(s) provided under the particular program align with the missions of the County's various departments to ensure as much consistency in mission as possible. Programs whose mission is solely focused on public health would not be recommended for potential transfer. However, programs with cross-cutting mission and operations, such as DPH's Alcohol and Drug Program Administration (ADPA), Antelope Valley Rehabilitation Centers (AVRC), Children's Medical Services (CMS), and Office of Women's Health (OWH), offer the potential for closer consideration of their placement in other departments. It is for this reason that the four programs identified above were originally identified and discussed in our September 16, 2009 memo.

In addition to mission alignment, two other factors this Office used to determine whether a County program should be organized under DPH or another County department include assessing whether: 1) the program has a population-based, prevention focus, rather than an individual, and/or safety net focus; and 2) the program would enable DPH to have a diversified portfolio of programs that contribute to DPH's mission, including health promotion and prevention as well as health protection and preparedness.

HEALTH AND MENTAL HEALTH SERVICES CLUSTER DEPARTMENTS' MISSIONS AND SERVICES

DHS, DMH, and DPH each provide an array of important services to the residents of Los Angeles County and are often grouped together in conversation regarding programs and services; however the three departments have distinct missions, roles, and responsibilities.

Department of Health Services

DHS specializes in providing a wide array of health care services ranging from primary care, specialty care, inpatient care, including acute psychiatric inpatient care, and emergency and trauma care services. The DHS services population are principally the low-income uninsured and Medi-Cal patients. DHS also organizes managed care through its Community Health Plan, and organizes and manages the County's overall emergency medical network comprised of public and private hospitals through its Emergency Medical Services Agency.

Department of Mental Health

DMH focuses on the organization and delivery of prevention and treatment services for persons with severe and persistent mental illness. The DMH service populations include adults, older adults, and children and youth.

Department of Public Health

DPH focuses on population-based disease detection and control, health promotion and prevention services, and services to unique and/or vulnerable populations which require highly specialized services such as Tuberculosis, Sexually Transmitted Diseases, Human Immunodeficiency Virus, maternal and child health, and substance abuse.

POTENTIAL PROGRAM TRANSFERS

While the following four programs were reviewed and discussed in our earlier report, we have included them again in this report, for ease of reference and, in some instances, to provide additional information regarding our review and justification for recommending that they remain as part of the DPH organization.

I. Alcohol and Drug Program Administration

The organizational placement of ADPA within the County was analyzed and it was recommended that it remain in DPH. Our report noted program and policy, fiscal and administrative, and operational issues associated with transferring ADPA from DPH to DMH. Among the reasons for keeping ADPA in DPH, was need to maintain a prevention focus with respect to substance abuse in addition to the organization and delivery of treatment services. This focus is similar to the DPH Tobacco Control and Prevention Program. As noted in the report, some of the substance abuse and mental health services need better integration that can be accomplished via an MOU between DPH and DMH.

II. Antelope Valley Rehabilitation Centers

The residential substance abuse treatment services provided at AVRCs have an inherent linkage with ADPA. DPH is currently working on improving the service quality at AVRC including the establishment of better service linkages to DMH, the courts, and other partners. At this time, it is recommended that AVRC remain under DPH.

III. Children's Medical Services

There are several reasons for recommending that CMS remain under DPH. CMS provides a broad spectrum of services including eligibility screening and treatment planning preventive screening, diagnostic, treatment, rehabilitation, and follow-up services. CMS is responsible for not only the direct care to eligible children, but also the certification of public and private providers that provide specialized health care services. CMS is also responsible for managing the County's Child Health and Disability Prevention Program which assures preventive health screening services for low income children though provider certification and training, and public health nursing follow-up for children with identified health problems. Finally, as a program within DPH, CMS maintains a close collaborative relationship with the Maternal, Child, and Adolescent Health Programs, thereby allowing the two programs to address the health care needs of children and families. For these reasons, it is recommended that CMS remain under DPH.

IV. Office of Women's Health

The mission of the Office of Women's Health (OWH) has evolved beyond its original patient care focus and treatment services for women. The program now focuses on a population-based approach with current activities emphasizing prevention. For this reason, it is recommended that OWH remain under DPH.

In addition to the programs above, the subsequent review included the following two program areas.

I. Emergency Medical Services

At the time of this Office's analysis of the proposed separation of DPH from DHS, EMS was a program whose responsibilities and organizational placement was specifically analyzed. Although this analysis was brief, this Office's June 9, 2005, memo to your Board clarified that although some of the services provided through EMS were similar in nature to that of DPH's Emergency Preparedness and Response Program (also known as the Bioterrorism Program), the primary mission of EMS was still different than that of the Emergency Preparedness and Response Program. Therefore, at the time of the separation, EMS was not recommended for transfer to the new DPH. Based on our current review of the EMS program, we continue to recommend that EMS remain under DHS organizationally.

Under the EMS Systems Standards and Guidelines, outlined in a September 2003 report to the Emergency Medical Services Commission, the functions of a local EMS agency are defined as planning, implementing, monitoring, and evaluating the local EMS system. Further 24 of the 31 local EMS agencies that responded to a statewide survey mirrored Los Angeles County's structure, as these local agencies were a division reporting to the Department of Health Services.

In adhering to its first mandate of planning, implementing, and operating the EMS system, DHS' EMS agency must coordinate the paramedic communications system and information systems technology. As part of this responsibility, EMS coordinates transfers to County hospitals through the Medical Alert Center. Further, EMS has a responsibility to maintain the public safety net by ensuring the availability of a core of base hospitals to direct field care in the emergency medical services system.

Although EMS has responsibility for disaster preparedness and planning, it must be noted that these preparedness and planning efforts relate directly and specifically to patient transfers between hospitals, as opposed to DPH's Emergency Preparedness and Response Program's broader mission of preventing and mitigating the public health consequences of natural and intentional emergencies for Los Angeles County residents through threat assessment, improved operational readiness, and timely response.

II. Public Health Clinic Services at DPH Health Centers

The services provided at DPH Public Health Centers are specialty in nature, as opposed to health care services delivered by DHS. Examples of these specialty care

services include the treatment of communicable diseases such as TB and STDs. Services also include immunizations and some HIV/AIDS testing and treatment services. One of the key reasons for aligning these clinical services in DPH is that they enhance the ability of DPH to perform disease investigation (contact tracing) and thus are part of the effort to control disease in the community. This is particularly important in TB which can spread easily, or STDs which is prevalent among certain groups who do not frequent traditional health care settings because of barriers to care or the need for anonymity. Clinical public health services also allow DPH to maintain a ready state capability to provide prophylactic medicines or vaccines, as evidenced by the recent H1N1 response. Finally, the alignment of intergovernmental public health funding streams within the same department allows for consistency and budgetary ease. For these reasons it is recommended that the DPH Public Health Centers remain under DPH's authority.

DPH SEPARATION AND THE IMPACT ON THE PROVISION OF SERVICES

Aside from the realization of the benefits and justifications outlined at the time of this Office's DHS-DPH separation analysis, such as addressing new and existing public health issues and avoiding potential budgetary impacts on DPH operations as a result of DHS' projected deficit, each of the two departments has experienced an increased ability to focus in on their core initiatives, as well as the level of services provided to the community.

By separating the two departments and allowing each organization to hone in on their core competencies, not only has the level of services provided by each department become more focused, but as mentioned above, intergovernmental public health funding streams have been aligned organizationally, TB and STD prevention and surveillance efforts have been protected, if not enhanced, by the data received through DPH Public Health Centers, and patient confidentiality has been protected.

SUMMARY

In conclusion, not only do organizational missions and competencies assist in determining the organizational placement of a particular program, but the understanding of and ability to meet the needs of the specific clientele/segment of the population, ensuring that a diversified portfolio of related services is offered and/or provided, and ensuring that the servicing department is the one most capable of and qualified to provide the type of care needed are all determining factors and/or tests taken into consideration when assessing the most appropriate organizational placement of a particular program.

Furthermore, as described above, the separation of DPH from DHS resulted in both departments being able to more sharply focus on the provision of services and the development and implementation of initiatives specific to their department. This ability to hone in on core competencies has allowed the two departments not only to maximize resources and opportunities, but as a result, to be more responsive to and accountable for the personal health care and public health of the County's residents.

If you have any questions please contact me, or your staff may contact Richard F. Martinez at (213) 974-1758 or at rmartinez@ceo.lacounty.gov.

WTF:SAS
MLM:RFM:bjs

c: Executive Officer, Board of Supervisors
Acting County Counsel
Interim Director, Department of Health Services
Director, Department of Mental Health
Director, Department of Public Health

120409_HMHS_MBS_DPH Program Report